London Ambulance Service NHS
NHS Trust

Annual Quality Account
2012/13
The annual quality report

The London Ambulance Service NHS Trust
Annual Quality Account 2012/13

An account on the quality of service provided by the Trust and the identification of improvement priorities for 2013/14

Incorporating an end of year review of the DH Ambulance Quality Indicators

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Introduction

Statement on Quality from the Chief Executive

Welcome to the fourth London Ambulance Service NHS Trust Quality Account. I came into post in January 2013 and I am proud to take over from Peter Bradley, the previous Chief Executive, who led the organisation through a significant improvement during his more than ten years in the service.

In an ever changing NHS I believe we can now build upon recent successes and the current high level of public confidence and capture the opportunities of increasingly professional and skilled staff to work within the new NHS and improve the way urgent and emergency care is provided to Londoners.

As you may be aware, NHS organisations are required to produce an annual Quality Account. The purpose of the document is to report on the quality of our services and the care we provide. We are accountable to our patients and this is one of the mechanisms that we use to answer that accountability. Therefore, the Quality Account is primarily written for a patient audience but it is also used by the Department of Health and has specific aspects that are required for their reporting arrangements.

We report on the progress we have made on the improvement areas we identified in last year's report and we also discuss our performance against the national quality indicators for ambulance services. We also use a number of other measures, such as complaints, to give the reader a more complete picture of quality.

The past year has arguably been the most challenging and exciting in our history. In a single year we saw London host the two biggest events ever performed in the capital. The first was the Diamond Jubilee held predominately on the River Thames and later in the year London hosted the Olympic Games. These gave us the opportunity to demonstrate one of our real strengths: our ability to provide business as usual to Londoners and simultaneously respond to the needs of planned events that change our operating environment. Our ability to do this is truly world class and this was highlighted as one of our quality targets for last year.

The preparations for the two world events were more time consuming than we anticipated but they brought great benefit to us and to London. London proved to the world what a great city London is to live and to work and we are proud to have played our small part in this unique event. In addition, we managed to improve in a number of our quality indicators and we met our most challenging performance target of reaching 75% of people within 8 minutes for the tenth consecutive year. But there are also areas where we failed to make the improvements that we wished to see. In particular we saw a reduction in our ability to address peoples needs and discharge them on scene. This resulted in taking a greater

percentage to accident and emergency departments than we would have expected.

We have seen demand increase by 6.4% and in particular the proportion of calls that result in a category A response, our highest priority level, has risen by 12.2% and this may offer some explanation as to why we took more people to accident and emergency. This rise in demand has given us a real challenge in meeting the needs of our patients in the lower priority categories and we have decided to focus on this group of patients for our Quality Improvement priorities in 2013-2015. Some of the specific improvement priorities are highlighted later in this Quality Account. We are proposing some significant changes that will bring dramatic quality improvements to this group of patients and allow us to improve the speed of our response. We know that from talking to patients and service users that the length of time it takes us to respond is the single most important issue. This will be another step in creating a world class service for London.

To the best of my knowledge, the measures reported within this Quality Account are true and accurate and reflect the services we provide.

Ann Radmore
Chief Executive

What is a Quality Account?

The purpose of the Quality Account

In 2009, as part of the Department of Health's drive to ensure quality receives equal status to finance and to also promote a greater degree of transparency, all NHS Trusts have been required to publish a Quality Account.

The Quality Account is required to follow a template and report on a set of mandatory items. It is divided into three distinct sections:

Section 1 contains a statement on quality from the Chief Executive Officer and this introduction.

Section 2 looks back at the previous year and reports against a set of mandatory measures. The section also reports progress made against the priorities we identified for improvement in the 2012-2013 Quality Account.

Section 3 looks forward to the year ahead and identifies new priorities for improvement.

Individual Trusts are able to report over and above the minimum requirements but they should represent a true reflection of quality.

Once produced, the Quality Account should have the same value and status within the organisation as the annual financial accounts and the same degree of rigor and challenge should be applied whilst being created and approved.

Once published staff, the public, and patients can access the Quality Account on line and use this to help set local priorities or identify areas for further challenge and scrutiny.

How are patients, the public, staff and commissioners, involved in designing a Quality Account?

It is fundamental to the process that patients and staff are involved in the development of the quality account and especially in the identification of the improvement priorities for the coming year.

Patients, carers and members of the public

This year, new DH guidance firmly identifies which statutory patient and public organisation needs to be approached in order to provide formal feedback. The guidance states that the "Health Watch" covering the geographical area of the health provider's headquarters is responsible. Therefore, for 2012/13 we have worked with LINk Southwark via the Patients Forum London Ambulance Service in obtaining the views of patients, carers and members of the public alongside other LINk members from various London Boroughs.

In addition, as an aspirant Foundation Trust we have a members group which has a membership of over 8,000 who are representative of our patient group. We regularly hold meetings and towards the end of 2012 we started to make suggestions regarding quality priorities for 2013/14 at the member's events. On 25 March 2013 we

held a member's event dedicated to "Quality and Innovation". At this event we specifically fed back the progress on our 2011/12 improvements and responded to a question an answer session on quality issues.

As part of our public facing work with our public education team we routinely ask for feedback on what our improvement priorities should be. This year we asked 62 patients about our priorities and asked them what the most important things are that we need to get right first time.

Overwhelmingly the most important thing for the public is that we respond quickly. This is at the point of call answering and a clinical team arriving on scene. Other important themes include our staff being skilled and courteous.

In April 2013 we also presented the main issues within this Quality Account to the Hillingdon External Services Scrutiny Committee.

Staff

Our main forums for obtaining the views of our workforce are via manager's meetings and through the staff in year surveys. These do not exclude other opportunities such as Executive ride outs when members of the Trust Board observe patient care and actively seek the views of staff.
In addition, feedback on quality also passes through the area governance meetings where staff can feed quality concerns into a local forum that reports centrally up to the Quality Committee and Trust Board.

The Trust Board

During the course of the year the Executive Management Team and the Trust Board review the priorities identified within the Quality Account alongside wider quality measures every month via a Quality dashboard. It is important to note that this Quality Account is an annual summary of the whole 2012/13 period. Members of the Trust Board, Operational Managers and other staff are involved in measuring and monitoring quality every month.

Commissioners

The Trust meets with commissioners in the form of the Clinical Quality Group. This has representation from the various clinical commissioning groups and representatives from the Trust and at every meeting we review the identified priorities and the remainder of the Quality Dashboard.

In addition, we have frequent review meetings with our lead commissioner in year to discuss issues such as Serious Incidents and performance.

Our Vision and Values

Our strategic direction and the values we uphold

Our vision is to be a world class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards Londoners having health outcomes that are among the best in the world.

Our strategic goals are:

To improve the quality of care we provide our patients

We will achieve this through the following objectives

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illness or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets

To deliver care with a highly skilled and representative workforce

We will achieve this through the following objectives

- Develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population
- Engage with our staff to improve patient care and productivity

To provide value for money

We will achieve this through the following objectives

- Use our resources efficiently and effectively
- Maintain service performance during major events, both planned and unplanned including the 2012 Games

Our 2012/13 Annual Report outlines some of the progress that we have made in meeting these objectives and is designed to compliment, rather than repeat, this Quality Account.

Our values

The values that we uphold as an organisation remain the same. We have seven values that underpin the culture of the London Ambulance Service and these are also known as our CRITICAL values from the acronym that they reveal.

These cultural values are:

Clinical excellence

We will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs.

Respect and courtesy

We will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy.

Integrity
We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.

Teamwork
We will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.

Innovation and flexibility
We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.

Communication
We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

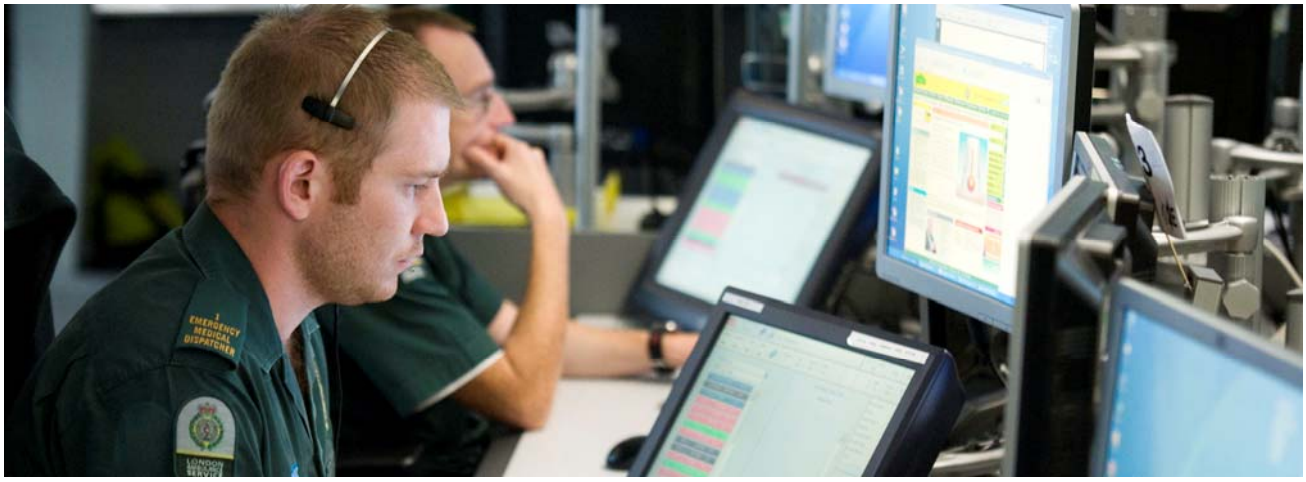
Accept responsibility
We will be responsible for our own decisions and actions as we strive to constantly improve.

Leadership and direction
We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

We believe that our strategic goals and our values provide a platform on which we can achieve or vision to be a world class service. Our vision is an aspiration that we use to determine our direction of travel. Work undertaken during the year has revealed great diversity throughout the world's ambulance services with different operating models and different quality measures and where there are common measures the data is not comparable due to a range of factors. However, we are giving some thought as to what milestones we can use to measure our ability to declare ourselves as a world class service. We will outline our thoughts within our new Clinical and Quality Strategy.

Prioritising Quality

How do we prioritise quality and identify our priorities



We believe that our patients are the key stone in our ability to monitor quality. However, as we provide services to a wide geographical area with no defined catchment our ability to engage a wide variety of patients in our work is challenging.

The Patient Voice

Whilst we have had some success this year and this Quality Account does report on a specific feedback project we need to test a model that supports engagement at a local level that maximises the role of our Community Involvement Officers.

We remain committed to working with our patients and are looking for opportunities for more inclusion and have added a regular "patient voice" item to our Learning from Experience Committee and will be inviting patient representation to our Quality Committee during 2013.

The Staff Voice

The annual Healthcare Commission Staff Survey highlights the importance of staff engagement and satisfaction.

High Quality Care for All (2008) stresses the importance of empowering staff, giving them the skills to provide a high quality service as practitioners, partners and leaders. Staff need to be supported to innovate to improve quality and this is echoed in the findings identified within the Francis Report (2013).

We run an annual survey and regular in year surveys to measure staff satisfaction and collect feedback. In addition the Chief Executive and senior managers regularly undertake observational shifts to work alongside staff to hear their issues first hand.

The role of the Trust Board

The Trust Board is accountable for ensuring the Trust consistently provides a safe and high quality service and this is demonstrated by the following

- Nominating a Director responsible for bringing quality issues to the attention of the Trust Board and acting as the custodian to quality issues.

- Prioritising quality on the agenda by ensuring these are, whenever possible, placed at the top of the agenda.

- Devoting the majority of its time discussing and acting on quality issues and the factors that influence quality.

- Having a Board level committee, with the same status (and linked to) as the audit committee, dedicated to quality monitoring.

- Monitors the quality of care provided across all our services and routinely measuring and benchmarking services internally and externally where this information is available.

- Proactively looking at any risks to quality and taking prompt mitigating action.

- Challenging poor performance or variation in quality and recognising quality improvement.

- Building a culture of listening, transparency and accountability. Listening to concerns from patients, carers and staff. The Trust Board now invites a patient to recount their experience to every Trust Board meeting.

- Working to ensure our workforce is as motivated as possible and enabled to deliver quality care.

Our Commissioners

The system for commissioning healthcare is evolving and on April 1 2013 changed to become clinically led and locally determined. Once the new system becomes familiar with the opportunities this brings for driving local improvements we expect to see local quality targets emerging.

For the time being we expect to continue with the current model of a single commissioner who commissions us on behalf of London. We currently work with our commissioner to identify what quality measures we need to routinely report. These are then reported to the Quality Group which has representation from the new local commissioners.

The Influence of Government Policy

For the past 3 years the Department of Health has published an NHS Outcomes Framework. This gives guidance to the wider NHS on what quality outcomes have been identified as critical to achieving the national priorities for health improvement.

The current framework was initially developed in December 2010, following public consultation, and has been updated and refreshed since its initial publication.

The Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas. They primarily focus on improving health and reducing health inequalities:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm

This definition supports the view that high quality care comprises: effectiveness, patient experience and safety. Consequently in order to use a single framework when talking about quality we have aligned our quality indicators within these domains. However, we have also retained our workforce indicators as a sixth domain as we believe our workforce is a critical element to maintaining quality.

From April 2013 provider Trusts will be required to publish quality measures in a way that will enable direct comparisons to be made with other Trusts via a mandated quality dashboard. This will not initially apply to Ambulance Trusts as they already report comparative information to the DH. However, it is likely that ambulances will be incorporated into the dashboards to allow local issues to be highlighted. This may mean that we need to adjust our current quality measures once there is clarification.

The national reporting has a different approach to quality and the DH has agreed not to set national targets or thresholds associated with each quality measure but to allow the measures to be interpreted locally. We have taken this a step further and are no longer focussing on achieving a target but are turning our attention to the number of patients that did not receive a particular standard. For example, if the 95% target of patients received the right care following a stroke is achieved we are now asking how many people did not receive the right care following their stroke and why. This work is

in development and we are starting to collect and audit information differently so that we can report this for the majority of our indicators.

The Expectations of our Regulators

Our regulator is the Care Quality Commission (CQC). They are responsible for setting the minimum standards for quality and safety that people have a right to expect whenever they receive care; Organisations that consistently meet these expectations are then registered with the CQC and are able to provide care to NHS funded patients.

The CQC then monitor the provision of healthcare at these registered providers using a variety of measures that include unannounced inspections and other methods of data gathering.

The CQC have had a difficult year and have completely re-evaluated and refreshed the way that they will inspect healthcare providers. From April 1 the inspection and regulation of care services will ask the following questions about services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

They are planning to appoint a Chief Inspector of Hospitals, and a Chief Inspector of Social Care and Support, and are also considering the appointment of a Chief Inspector for Primary and Integrated care.

The CQC will be moving towards inspections being determined by the 'risk' involved. By this they mean the quality and safety of a service, and the type of care being provided. They will inspect services more often where there is a high risk of harm to people who use them, and where people are vulnerable because of their circumstances, such as services caring for people with learning disabilities, those caring for people in their own homes, and those caring for people with mental health issues.

The CQC intend to develop new fundamental standards that focus on the new five areas, working with the public, people who use services, carers, providers and professionals.

The Trust Development Authority

The Trust Development Authority (TDA) is a new organisation aimed at ensuring all NHS provider Trusts who are not Foundation Trusts have a facilitated transition to being able to register with Monitor and become a Foundation Trust. They have created a quality directorate at the very centre of their organisation, which is designed to give locally-focussed Delivery and Development Teams guidance on the key measures for success. Undoubtedly as 2013 progresses we will become more aware of the quality expectations of the TDA and will need to incorporate these within our quality plans for the coming year.

Review of the Year 2012/13

Quality in general

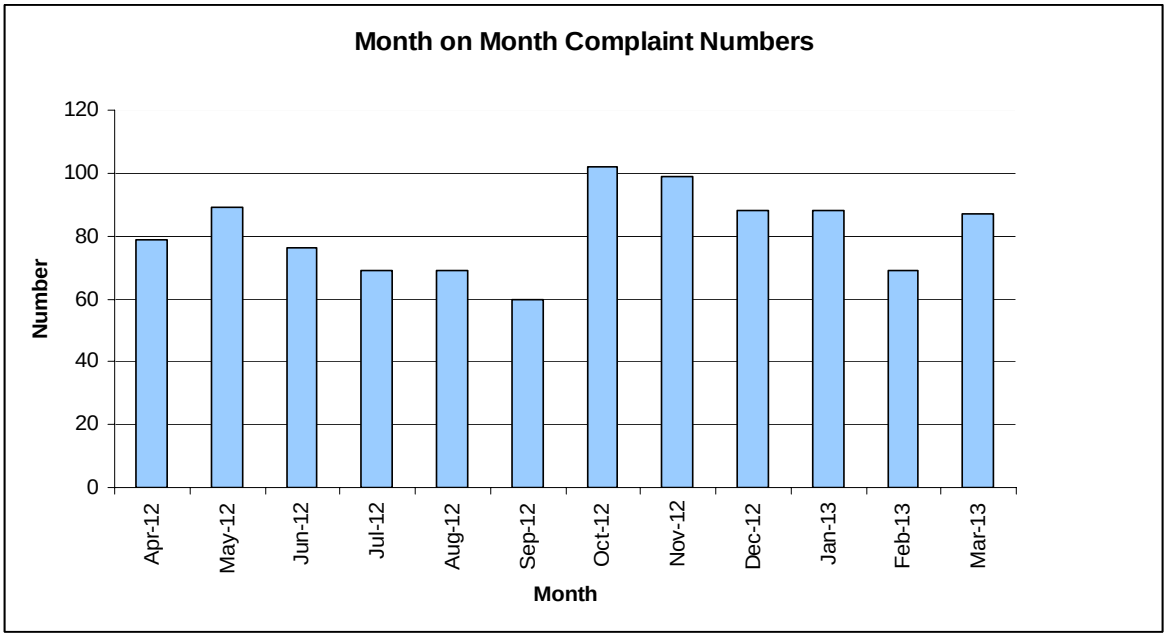
We use a wide range of indicators to give us a measure of the level of quality we are offering and these are specifically reported later in the Quality Account. However, we also use a range of routine indicators to help triangulate the information. Some of these are reported within this section.

Complaints

We have seen an increase in complaints during 2012/13 compared to the previous year.

The main theme has been delays in the ambulance being dispatched, especially to patients triaged within our medium priority level which we call C1 and C2. This undoubtedly reflects the increased activity to the Trust with demand continuing to rise year on year.

For each complaint that we receive we undertake a comprehensive explanation which includes, if necessary, a quality assurance evaluation of the emergency call received. This allows us to identify whether the 999 call was handled appropriately and to determine if the caller received the correct information. In the majority of cases the call was handled correctly and the cause of the poor patient experience was purely down to us being unable to match the demand with an available resource.



We also continued to receive complaints about poor staff attitude and behaviour. The most likely cause for a complaint of this nature is when our clinical staff challenge the patient about the validity of their 999 call. Similarly we also receive complaints when our call takers refer patients to telephone advice rather than a face to face response. This is a difficult situation for the Trust as we have a responsibility to use our resources appropriately. However, we are developing a plan to try and reduce the unhappiness experienced by patients when we do not respond in the way they expect.

We have made concentrated efforts this year to learn from patient feedback about a wide range of issues relating to the 999 call management function. This has included changing the information we give to 999 callers.

We have also identified from complaints that we receive poor information from some community alarm providers when a patient activates their alarm. This is usually because the provider is remote from the patient and many authorities now use the 999 as the default response to an alarm activation.

During 2012/13 we had 29 cases progress to the Health Service Ombudsman for further enquiry. 1 of these was subject to further investigation suggesting that the quality of our complaint response is of a good standard. However, in that 1 case the recommendation was made that we need to improve our maintenance of chronological records when we meet with complainants.

Serious Incidents

We had 1,708,597 calls for assistance in 2012/13 and 16 resulted in a serious incident. This is a low ratio to our work. However, we must ensure we learn all the lessons that are contained within all serious incidents.

There are no overall themes. However, we deliver 1,000 babies a year and considering all of these are out of the planned environment some do result in difficulties. Therefore we had a number of serious incidents regarding challenged labour last year.

We had a number of serious incidents where patients had been categorised correctly but due to the demand on the service we had been unable to give a response within the target time. This is unsatisfactory and we are in discussion with our commissioners on how we can ensure we respond appropriately to all calls and this forms the basis of our improvement priorities for 2013/14.

Patient Feedback

In 2012/13 we agreed with our commissioners to undertake a major satisfaction survey of patients who have not been conveyed to hospital, to elicit information about their experience. The project also asked clinicians and call answering staff about their experience of making decisions not to convey patients to hospital, and the factors that affect their decisions.

We approached 599 patients and 178 took up the opportunity to give feedback and 116 members of staff participated in the feedback.

On the whole patients were happy with the service being provided although the patients receiving hear and treat reported slightly less satisfaction than the patients receiving see and treat. Some respondents had concerns about the validity of assessing patients over the phone and then about the way that they were spoken to by Trust staff. Amongst the see and treat patients it was attitude that contributed to the lower satisfaction.

However, only 4% of the patients reported that the call taker had been poor when asked about courtesy and the score was 3% for ambulance staff. However, 1% reported that they hadn't been involved as much as they wished during hear and treat but this was 5% for see and treat.

Patients gave positive comments on the way that they were treated and some of the quotes include

"Always calming, reassuring and helpful"

"They keep you calm and do everything for you"

"I have always received excellent care from the ambulance service and am most grateful to them. They do a fantastic job"

Some patients also took the opportunity to give feedback that identified the need to improve. These included

"I have called for an ambulance twice for my illness and both times an ambulance has not been dispatched. It amazes me how a grading system determines if an ambulance comes to you or not. I feel this would only encourage people to exaggerate their symptoms. My illness led to hospital treatment, MRI scans, more treatment and now on going with the GP. An ambulance should have been sent"

The exercise revealed that some patients call 999 as they are unaware of the alternatives that are available; such as out of hours GP services. For others, they had dialled 999 because they believed the ambulance staff would be able to administer pain relief.

With regards to our staff the exercise revealed that our staff may not be clear about policies or guidelines that relate to non-conveyance and staff were asking for greater clarity. Interestingly, staff who used to be part of our Emergency Care Practitioner team seemed to be more confident about leaving patients at home but there was a call for more training in managing the less urgent patients and the alternatives that may be available.

Staff Survey

A total of 1,659 London Ambulance Service staff completed the 2012 NHS Staff Survey, a response rate of 37% (The response rate in 2011 was 39.5% or 1793 employees). The survey enables staff to provide feedback on their experience of working for the Trust.

The results show a number of improvements from the 2011 survey, which include:

- A 10% reduction in staff reporting that communication between senior management and staff is not effective (67% in 2011 and 57% in 2012)
- The percentage of staff reporting that they cannot meet conflicting demands on their time at work has fallen by 8% (43% in 2011 and 35% in 2012)
- The percentage of staff who felt they were not able to do their job to a standard they are were pleased with fell by 5% (28% in 2011 and 23% in 2012)

However, the following areas have been identified as areas requiring action:

- The percentage of respondents reporting that there are not enough staff at the Trust to do their job properly rose by 10% (54% in 2011 and 64% in 2012)
- The number of staff reporting that they have experienced harassment, bullying or abuse from patients rose by 19% (33% in 2011 and 52% in 2012)
- The percentage of staff who felt unwell as a result of work-related stress increased by 10% (39% in 2011 and 49% in 2012)
- The percentage of staff who reported that they are not able to make improvements in their area of work increased by 10% (43% in 2011 and 53% in 2012)

A Trust wide action plan has been produced to tackle the areas of concern. Actions include increasing face-to-face communication between senior management and staff, through road shows and listening events which will encourage staff to share their ideas. In addition access to health, wellbeing and stress management support is to be improved and recruitment is underway to significantly increase clinical staffing levels. The plan is supplemented by actions agreed at ambulance station and department level, based on local breakdown of results.

A summary of the Trust's results can be found on the Department of Health's website, although it should be noted that this report is based only on a small sample of the total respondents.

The 2012/13 Quality Indicators

2012/13 saw the Ambulance Quality Indicators (AQIs) have their second year. They were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients.

The indicators are specific to the ambulance service but are designed to be read alongside the indicators for Acute Trusts that have Accident & Emergency departments. They measure elements of patient safety and patient outcomes

Constantly monitoring our performance is essential and it is a vital indicator of how well we respond to patients' needs and how we can maintain and improve our standards of care. Response times remain important for the most seriously ill patients and all NHS ambulance services must respond to 75% of calls to life-threatening emergencies within 8 minutes and 95% of these calls within 19 minutes. These two time related indicators form part of our contract and have penalties associated with under performance.

A Culture of Continuous Learning

Following on from our role in the development of the *Urgent and Emergency Care Toolkit* we used the toolkit during 2012-13 to quality assure the care being provided to 999 callers who were not in need of an ambulance but received advice over the telephone (known as hear and treat). Over a 9 month period 333 audits were undertaken by independent reviewers. Throughout the year 13 aspects of the audit assessment showed a consistent achievement above 90%. The 14th assessment (documentation) started at 60% and improved to 80% across the year.

Individual feedback was provided to clinicians undertaking the assessments. The complex nature of the patient pathway for urgent care and the variety of different types of care workers with direct patient contact means that such services face particular challenges in ensuring continued monitoring of clinical standards for consistency and quality improvement.

The Toolkit *w*ill help provide a seamless approach to promote quality care across a range of NHS services, including, out of hours doctors, emergency departments, walk-in centres, GP practices, pre-hospital emergency care doctors, NHS Pathways, NHS Direct, the Ambulance Service, and urgent care centres.

The new toolkit provides practical guidance to providers on checking the quality and care provided and continually learning from experience to improve care regardless of setting.

Our 2012/13 Quality Priorities

Progress against our improvement priorities

Last year we used six main pieces of work to inform the selection of our quality improvement priorities. These were 1) the NHS Operating Framework 2) patient ideas 3) staff ideas 4) learning from incidents 5) commissioning intentions and 6) the quality indicators.

From this analysis we identified the four areas as;

- Mental health care
- Alcohol related harm
- Maintaining quality during the Olympics
- Treatment and care of Diabetes

Mental Health Care

In recognition of the vital role we play in the emergency and urgent care of patients with mental health conditions we identified mental health care as an area for quality improvement in the previous year and decided to continue this work in 2012/13.

Building upon the success of the previous year we identified four specific areas for action which are outlined below. We have had mixed results this year. Undoubtedly the care of mental health patients has continued to progress and we are increasingly being seen by other NHS organisations as a mental health provider. As a result of our work we now have stronger networks and our liaison with the London Mental Health Trusts has considerably improved.

Action area 1: To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face-to-face element of training in the coming year.

We incorporated mental health training within the third day of our statutory and mandatory training programme. This approach would ensure that every clinician would receive an update during 2012/13.

To support this training and also ensure that the classroom time was maximised we also asked our clinical staff to complete the on line mental health package prior to attending the classroom training.

Unfortunately the rise in Category A demand made it extremely difficult for us to deliver all of our training aspirations within 2012/13. As soon as it became apparent that we would be unable to deliver on all our training objectives we had to reprioritise. Unsurprisingly we had to focus on preparing our staff for the Olympic Games. Nevertheless, mental health training remains part of our statutory and mandatory training and has been rolled into 2013/14.

Action area 2: To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.

In 2012 we appointed a Clinical Advisor for Mental Health. We believe we are the only Ambulance Trust to make such an appointment and this role is central in our ability to advance the support available to our clinical staff. The post holder is prioritising our team of clinical advisors but this has taken longer than initially anticipated due to changes we are making within our support team and also due to the limited training opportunities within the past year. This has been rolled into 2013/14.

Action area 3: To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.

As we had undertaken a patient feedback exercise with patients with general mental health disorders in the previous year we decided to focus on a different group of mental health patients in 2012/13 and decided to incorporate a satisfaction element into our alcohol recovery service which is reported within the next section.

Action area 4: To role out the agreed care pathways across the whole Trust.

There are 11 NHS Trusts that provide mental health care to Londoners. During 2012 we completed the negotiation of mental health care pathways with all of these providers and implemented them in March 2013.

This means that all the mental health providers will now accept a referral from a paramedic for patients with chronic mental health conditions and have agreed that we can access their out of hour teams for additional support or advice. This means that once these agreements are embedded within our clinical practice we should convey less patients to an accident and emergency department.

Our base line figure for 2011/12 shows that we conveyed 12,833 patients to accident and emergency with mental health conditions. It is important to remember that for some of these patients the accident and emergency department would be an appropriate choice and we are unlikely to see reductions in large numbers. Nevertheless, for a significant number of patients with chronic conditions, such as dementia and depression we should see improved mental health care.

Alcohol Related Harm

Alcohol continues to receive widespread media attention and it is a high priority across London for a number of other organisations; such as the office of the London Mayor and we identified as a priority as it features consistently across all the six elements we used to identify our priorities.

We broke the improvement area into two main work streams 1) our alcohol recovery service and 2) health promotion and this was supported by the CQUIN reward framework which was used to support the implementation of this objective.

Alcohol Recovery Service

In order that we can meet the resourcing challenge of managing large numbers of intoxicated patients at weekends we use our Alternative Response Vehicle which we established 6 years ago. These vehicles can carry up to 5 patients at one time and convey intoxicated patients to Emergency Departments. This helps us to ensure front line ambulance resources can attend other emergency calls and also allows the clinicians who work on the Alternative Response Vehicle to develop expert skills and confidence in caring for what can be a challenging group of patients.

In 2010 we developed this model further and commenced the Soho Alcohol Recovery Centre pilot. This was an innovative alternative care pathway for patients with alcohol intoxication where intoxicated patients were brought to this centre where they received care until it was safe to discharge them back into the community. The pilot initially ran over the Christmas and New Year period in 2010 and 2011. Last year we agreed with our commissioners to run this service over all weekends and to evaluate this as part of our quality improvement priorities for 2012/13 with 2 specific actions for us to report against.

Action area 5**:** To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy.

Action area 6: To make recommendations to our commissioners on the future delivery model for alcohol.

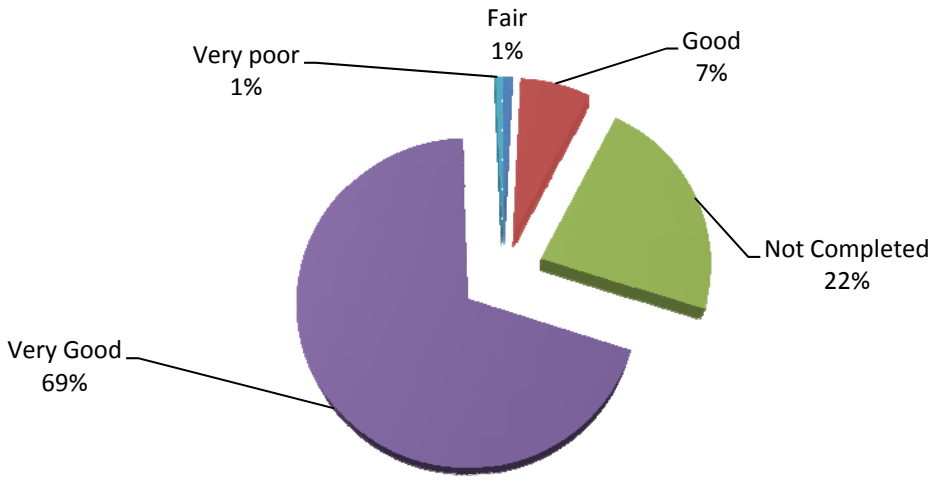
We successfully ran the project for the whole of the commissioned period and submitted a full evaluation report to our commissioners so therefore achieved both of the improvement areas identified.

During the course of the project the numbers attending the service fluctuated from less than 5 to more than 40 over a weekend period. However, the vast majority of weekends saw more than 20 patients use the service. This means that we regularly prevented more than 20 patients every weekend being taken to St Thomas' Accident and Emergency department.

We evaluated the quality of the service offered to patients by asking for an evaluation questionnaire to be completed. The results were overwhelmingly positive. 22% of patients declined to complete the questionnaire whilst 69% of patients stating their service experience was very good.

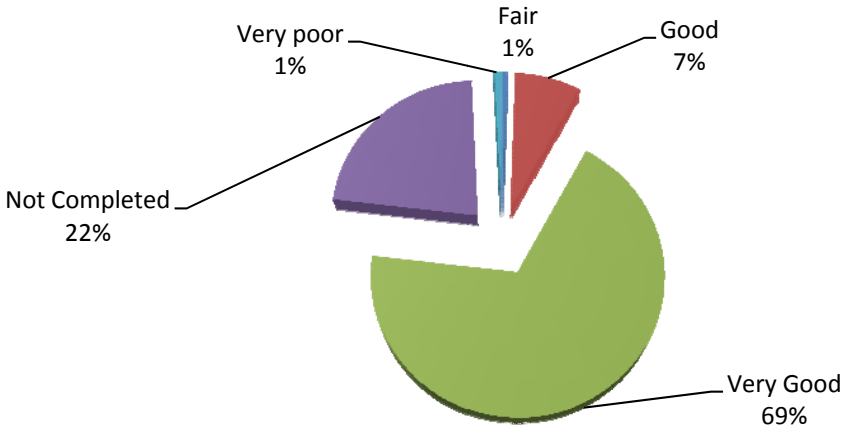
The following chart illustrates the experience rated from very good to very poor.

Respondent's Overall Satisfaction with the SARC



We also evaluated a number of other elements. Worth noting in this Quality Account is the satisfaction regarding the information provided on discharge. Once again 69% of patients said the information was very good with only 1% stating that it was poor. This is illustrated in the following chart.

Respondent's Satisfaction with Information Provided



Overall we believe the alternative management of intoxicated patients has been a success and our commissioner has agreed to extend the service into 2013/14 to give time to evaluate the cost effectiveness of the service and secure sustained commissioning for the service

Health Promotion

We agreed with our commissioners to use our work with alcohol to test new ground in health promotion. We have been undertaking health promotion in areas of emergency care for a number of years. For example, we undertake health check schemes at shopping centres and participate in gun/knife crime prevention work.

However, we do not routinely participate in the "every contact is a health promotion opportunity" concept. Whilst we support the notion that all health care professionals should maximise any contact with patients as an opportunity to share knowledge and health promotion advice we have not routinely incorporated this into practice. This quality improvement priority was our first attempt and we set two specific action points.

Action point 7: To identify three ambulance stations where we can introduce an alcohol assessment protocol.

Action point 8: To identify what course of action can be taken when a patient triggers the assessment.

Three complexes (Camden, Islington and Croydon) were identified as pilot sites to receive training in the use of an alcohol assessment tool called AUDIT-C and to deliver alcohol information leaflets to those screening positive. These three complexes were selected on the basis of their high level of exposure to alcohol related incidents and due to their history of activity and involvement in the subject area.

The AUDIT-C (Alcohol Use Disorders Identification Test Consumption questions) is a validated questionnaire that is designed to detect those at higher risk of hazardous or harmful drinking. Those scoring 5 or above out of a maximum possible 12 are deemed to have screened positive for higher risk drinking and therefore may benefit from further screening alcohol advice and brief interventions.

Technically the specific action points were achieved. However, the results were disappointing with a disappointing low number of patients receiving the assessment. We had predicted up to 3000 patients per quarter would be screened but we didn't see numbers go beyond 200.

The staff evaluation as part of the scheme revealed that the majority of our clinical workforce (76%) did not feel this type of assessment was appropriate to their role. This clearly needs further exploration and discussion and in the short term we have decided not to continue this piece of work until we have the opportunity to consider the

wider role of our clinicians in health promotion.

Maintaining Quality During the Olympics

In recognition that the public were concerned about the Olympic and Paralympic period we explicitly identified maintaining quality as one of our quality improvement priorities for 2012/13.

We were committed to ensuring that London received a normal service during the Games and we proposed to put into place a number of measures that would maximise our ability to deliver a normal service.

We identified three strategic objectives for the Olympic period:

- Preserve lives, and protect patient care throughout the Games period
- To ensure sufficient resources and management assets are available to manage core activity to national and locally agreed quality standards
- To maintain the reputation of the Trust with the general public and stakeholders

To support the delivery of these three objectives we identified five specific action points.

Action point 9: We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic demand and capacity review meeting to review the latest position and initiate actions as required.
A group was established to provide the strategy and oversight to ensure that the Trust was prepared and able to maintain service delivery throughout the period of the Olympics and Para-Olympics. The main objective of the group was to preserve lives and protect patient care throughout the Olympic period as well as ensure sufficient assets and management functionality is available to manage core activity in preparation for restoration of the new normality. The group provided central leadership where appropriate resolving any risks and issues, enabling the Trust to manage business as usual.

An action log was created and was in place throughout the Games period. All actions were assigned and had responsible owners and deadlines by which they needed to be discharged. This encouraged operational ownership and accountability.

Action point 10: We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the Games.

To ensure clinical support for control room staff and our frontline crews a bespoke clinical hub was established within our main control room at Waterloo. This hub was staffed with highly skilled and experienced paramedics who were trained in the use of an enhanced clinical assessment software tool.

These paramedics also provided additional capacity to our existing cohort of clinical telephone advisors and enabled us to conduct higher levels of hear and treat to appropriate groups of patients identified through our initial triage process as having minor injuries or illnesses that did not warrant the attendance of an ambulance. This initiative continued post Olympic Games and the expansion of our hear and treat service has now been formally funded by our commissioners.

Action point 11: We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.

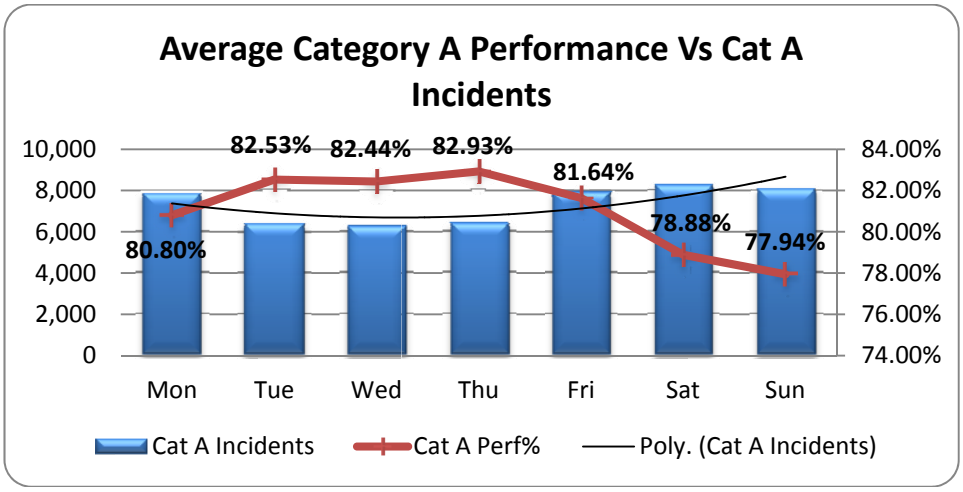
With demand on the Service expected to increase during the Games, support services staff were asked to play their part to assist frontline colleagues during the Games. Staff, who are not expected to see an increase in their workload during the Games, were asked to volunteer for a variety of roles, freeing up more A&E operations staff to treat patients.

Action point 12: These messages will be communicated as required and need to be reinforced by robust local messages.

Key messages were communicated to staff on a daily basis, covering clinical updates and information briefings. Teleconferences were held in a supportive environment encouraging problem solving from all involved as well as sharing good practice across all areas.

Action point 13: Identify the quality indicators to monitor in real time during the period of the 2012 Games.

We maintained our performance over the Olympic Games period and provided an excellent service to the rest of London. This is illustrated in the following graph.



Treatment and Care of Diabetes

We decided to continue to focus on long-term conditions and build upon our success with our "falls" priority in the previous year. We identified diabetes as a priority area for 2012/13 and this was supported by the CQUIN reward framework which was used to support the implementation of this objective. In particular, those patients who suffered a hypoglycaemic episode and recovered, and also those patients over 40 years of age who on a random blood sugar testing have been identified as having a raised blood sugar level.

We identified one specific action point;

Action point 14: Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.

We decided to develop a new protocol for appropriate advice and onward referral of patients found to have a raised blood sugar level. The aim of the project was to prevent long term complications; improving long term health care, related costs and reducing associated morbidity.

Unfortunately we did not see the number of referrals that we anticipated but the results were very positive.

- 93% of GPs found the hyperglycaemia referral pathway either quite or very helpful.
- 95.5% of patients who were indicated to have follow up blood tests received them.

In addition we developed a project for a reduced blood sugar level. The aim of the project was to develop and implement a London specific pathway for the onward referral of insulin dependent diabetic patients who have recovered post treatment from an episode of hypoglycaemia and are remaining in the community. By integrating pre-existing systems along with using GPs as a single point of access for onward referrals, a new referral pathway was developed to ensure best practice and launched in October 2012.

The pathway was successfully launched and has been received positively by all involved. The implications of operational pressures and subsequent launch delays along with an inconstant approach to staff training resulted in missed trajectory targets. However, the 2 hour welfare check had a 90% success rate and of those patients receiving a subsequent ambulance response 20% required additional medical assistance proving the robust nature of the system. Similarly of the referrals made to GP's 78% received additional follow up with 50% resulting in further intervention.

Technically we achieved the action point but as we did not achieve the referral numbers that were anticipated we failed to meet the threshold of the CQUIN.

Summary of achievements

2012/13 was a mixed year for meeting the specific quality improvement priorities. These are summarised in the following table;

	Achieved	Partially Achieved	Not Achieved
Action area 1: To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face-to-face element of training in the coming year.			✓
Action area 2: To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.		✓	
Action area 3: To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.	✓		
Action area 4**:** To role out the agreed care pathways across the whole Trust.	✓		
Action area 5: To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy.	✓		
Action area 6**:** To make recommendations to our commissioners on the future delivery model for alcohol.	✓		
Action point 7**:** To identify three ambulance stations where we can introduce an alcohol assessment protocol.	✓		
Action point 8: To identify what course of action can be taken when a patient triggers the assessment.	✓		
Action point 9: We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic demand and capacity review meeting to review the latest position and initiate actions as required.	✓		
Action point 10**:** We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the Games.	✓		
Action point 11: We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.	✓		
Action point 12: These messages will be communicated as required and need to be reinforced by robust local messages.	✓		
Action point 13**:** Identify the quality indicators to monitor in real time during the period of the 2012 Games.	✓		
Action point 14**:** Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.		✓	

Mandatory Assurance Statements

The mandatory statements as mandated by the DH

Statement Area 1: Data review
During 2012/2013 the London Ambulance Service NHS Trust provided three NHS services and has reviewed the data available to them on the quality of care in all three of these NHS services.

Statement Area 2: Income
The income generated by the NHS services reviewed in 2012/2013 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2012-2013.

Statement Area 3: Clinical audit
During 2012/2013, three national clinical audits and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audits that the London Ambulance Service NHS Trust was eligible to participate in during 2012/13 are as follows:

- Department of Health Ambulance Clinical Quality Indicators covering:
  - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
  - Outcome from cardiac arrest – Survival to discharge
  - Outcome from acute ST-elevation myocardial infarction (STEMI)
  - Outcome from stroke
- National Clinical Performance Indicators (CPI) programme covering:
  - Hypoglycaemia
  - Asthma
  - Lower leg fracture
  - Febrile convulsion
- National Ambulance Non-Conveyance Audit (NANA)

The national clinical audits that the London Ambulance Service NHS Trust participated in during 2012/13 are as follows:

- Department of Health Ambulance Clinical Quality Indicators:
  - Outcome from cardiac arrest –ROSC
  - Outcome from cardiac arrest – Survival to discharge
  - Outcome from acute STEMI
  - Outcome from stroke
- National CPI programme:
  - Hypoglycaemia
  - Asthma
  - Lower leg fracture
  - Febrile convulsion
- NANA

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 2790 b) 368	a) 2790 b) 368	100%
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 2725 b) 344	a) 2725 b) 344	100%
DH ACQI: Outcome from acute STEMI a) Thrombolysis delivered within 60 minutes of call b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 1 b) 929 c) 1745	a) 1 b) 929 c) 1745	100%
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 3888 b) 6637	a) 3888 b) 6637	100%
National CPI: Hypoglycaemia a) Blood glucose before treatment b) Blood glucose after treatment c) Treatment for hypoglycaemia recorded (oral carbohydrates, glucagons, IV glucose) d) Direct referral made to an appropriate health professional e) Care bundle	600	600	100%
National CPI: Asthma a) Respiratory rate recorded b) PEFR recorded (before treatment) c) SpO_2 recorded (before treatment) d) Beta-2 agonist recorded e) Oxygen administered f) Care bundle	900	900	100%
National CPI: Lower leg fracture a) Two pain scores recorded b) Analgesia administered c) SpO_2 recorded (before treatment) d) Oxygen administered e) Immobilisation of limb recorded f) Assessment of circulation distal to fracture recorded g) Care bundle	58	58	100%
National CPI: Febrile convulsion a) Blood glucose recorded (before treatment) b) Temperature recorded (before treatment) c) SpO_2 recorded (before treatment) d) Oxygen administered e) Anti convulsant administered f) Temperature management g) Appropriate discharge pathway recorded h) Care bundle	145	145	100%
NANA: a snapshot audit of ambulance non-conveyance practice for 999 calls attended on the 24th October 2012 for a 24 hour period; including re-attendance within the subsequent 24 hour period a) Patient demographics b) Highest level of clinician at scene c) Patient Assessment d) Intervention e) Reason for non-conveyance f) Safety netting	23	23	100%

In addition, the London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to seven patient groups (see box below) and quality assures the documentation on 2.5% of all clinical records completed. We also undertake four continuous audits that monitor the care provided to every patient who suffers a cardiac arrest, STEMI or stroke, or who have been involved in a major trauma incident.

Information: Clinical Performance Indicators (CPIs) are designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. They focus on clinical areas where there is strong evidence of the care that leads to the best outcome for patients, or where there is a clinical risk associated with the patient group. The areas of care included are: acute coronary syndrome, cardiac arrest, difficulty in breathing, glycaemic emergency, stroke, mental health, patients that are treated and left at scene (non-conveyed) and general documentation. The delivery of care to these patients groups is routinely fed back to staff on a one-on-one basis by clinical supervisors so that staff are able to discuss how they can improve their performance. This process has led to clear documented improvements in care since its introduction.

The report of two national clinical audits were reviewed by the provider in 2012/13 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Raise awareness of the STEMI care bundle by developing an acute coronary syndrome aide memoire to highlight all elements of the care bundle as well as ECG interpretation and the correct pathways for this group of patients.
- Raise awareness of the stroke care bundle by creating a multimedia training package in collaboration with other NHS Trusts.
- Increase the number of referral routes for diabetic patients in London by introducing direct referrals and follow up care.
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by introducing portable oxygen saturation monitors with both adult and paediatric probes.
- Increase the number of patients with asthma who have their peak flow rate measured before treatment by asking staff for their ideas for improvement and implementing these actions as appropriate.

The reports of ten local clinical audits were reviewed by the provider in 2012/2013 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Mental Health Care

- Ensure staff are familiar with the definition of the terms ‘neglect’ and ‘vulnerable adult’ by providing training to staff.
- Clarify the indications for, and the use of, the capacity tool by reviewing the core skills refresher training.
- Identify whether a patient’s condition has previously been diagnosed by amending the patient report form to prompt staff to document the name of the patient’s GP or other current health care professional such as a psychiatric nurse.
- Introduce a risk assessment tool that can be used by staff attending patients who present with a mental health disorder.
- Monitor and improve the care given to patients with a mental health disorder by introducing a new CPI and providing feedback to staff.

Paediatric pain re-audit

- Make it easier for staff to administer larger doses of paracetamol to older children by revising the presentation of liquid suspension paracetamol.
- Incorporate paediatric pain management into pain training sessions to educate staff in the appropriate techniques for children experiencing pain and the correct doses of analgesia.
- Review the paediatric immobilisation training to ensure staff are educated in the immobilisation options available.

Assessment of paediatrics patients with pyrexia

- Assess whether leaving patients at home when their medical history indicates conveyance presents a serious risk to the patient by reviewing identified cases and feeding back to staff if necessary.

- Remind staff of the current guidelines and protocols for assessing and treating paediatric patients with pyrexia by issuing a poster to all ambulance stations and writing an article for the London Ambulance Service Clinical Update.
- Ensure training on paediatric care delivered to staff includes the importance of making a direct GP referral when paediatric patients are not conveyed, and taking two sets of observations 20 minutes apart.

Paediatric respiratory assessment

- Advocate the necessity of infant respiratory assessment by incorporating paediatric respiratory assessments into the core skills refresher training and the CPIs.
- Determine whether there is a shortage of oxygen saturation probes in specific areas of London and investigate if documentation regarding shortages is provided elsewhere by reviewing further records.
- Review the scale of the equipment concerns on the risk register.

Sudden Unexpected Death in Infants, Children and Adolescents

- Display posters on all ambulance stations to remind staff of the importance of documenting the receiving clinicians name for children who have died unexpectedly.
- Increase use of the 'Child at risk/in need report form (LA279)' by renaming it to reflect its additional use as a notification of contact form and designing a safeguarding memory aide that explains when an LA279 should be completed.
- Evaluate the LA279 referral process by conducting a trial to receive this information via the telephone.
- Determine whether it is possible to store LA279s electronically to ensure information is easily accessible and that storage complies with the LAS Records Management and Information Lifecycle Policy.
- Improve joint compliance to the 'Working Together to Safeguard Children' guidelines by communicating the results of this clinical audit with London Safeguarding Children Boards.

Alcohol intoxication

- Publish an article in the Clinical Update and produce posters for every ambulance station that remind staff of the importance of eliciting a full and accurate history for this patient group.

Alternative care pathway (ACP) use

- Publish an article in the Clinical Update and produce posters for every ambulance station that encourage staff to consider conveying a patient to an ACP if it will not prolong journey time greatly, even if the ACP is further away than the nearest Emergency Department.

Immediate inter-hospital transfers

- Ensure all necessary information is sourced during the initial call by working with other UK ambulance services to review the suitability of Medical Priority Dispatch System Protocol 35 for inter-hospital transfer calls and communicating to Emergency Medical Dispatchers the importance of following protocols.
- Ensure the Clinical Support Desk (CSD) record all advice given and escalate calls appropriately to on-call advisor when necessary by implementing quality assurance process to monitor the CSD log.
- Remind hospital staff of the criteria for inter-hospital transfers and their responsibility to provide an appropriate escort for the patient by reviewing and reissuing the inter-hospital transfers flow chart.

Transient loss of consciousness

- Educate staff in the pathology of T-LOC and encourage them to convey patients to hospital, or refer them directly to their GP, by reviewing current training packages, running a T-LOC study day and producing a prompt card.
- Assist staff to recognise the ECG findings specific to T-LOC by validating a mnemonic with the important ECG abnormalities.
- Prompt staff to explain 'other abnormality' and family history by adding another box to the patient report form.

Obstetrics emergencies

- Review current training packages and deliver a series of maternity update teaching sessions to remind staff of the importance of documenting all relevant information on the patient report form.
- Inform staff that any new skills learnt should not interfere with LAS taught skills by writing a Clinical Update article to remind staff of their training obligations.

- Develop an aide memoire to remind staff of the procedure for managing obstetric/obstetric emergency patients.
- Demonstrate the frequency of midwife non-attendance by sharing the clinical audit findings with the London Heads of Midwifery and Local Supervising Authority Midwifery Officer.

Statement Area 4: Research

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 284.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep up to date with the latest possible treatment options and active participation in research leads to improved patient outcomes.

The London Ambulance Service NHS Trust was involved in conducting three clinical research studies in pre-hospital care during 2012/13. There were 417 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2012/13. These staff participated in research covering two medical specialties. These were:

- DANCE (high risk acute coronary syndrome): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.
- Paramedic SVT: RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.
- SAFER 2: Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.

It is important to note that as well as recruiting patients we also conducted research involving staff and student paramedics as participants. These recruitment numbers have not been included in the 284 figure above, which only includes patient numbers. The total number of LAS staff and student paramedics participating in research as participants in 2012/13 was 581.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2012/13 are displayed in the following table.

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Study name 2012/13	Participants recruited	LAS clinical staff involved
NHS REC approved studies involving patients		
Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER2)	284	87
High Risk Acute Coronary Syndrome (ACS) (*formerly known as 'DANCE'*)	100	250
Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT)	32	80
Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review)*		
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	390 (in follow-up)	-
Professionalism and conscientiousness of trainee health professionals	94	-
The use of Section 136 of the UK mental health act in SW London	4	1
A Critical Discourse Analysis of Paramedics' talk about their administration of analgesia to patients who are cognitively impaired	12	1
Are psychological and emotional welfare measures in the UK proportional to the levels of stress experienced by responders after a disaster?	1	-
Identification of emergency and urgent care system characteristics affecting preventable unplanned admission rates	2	-
An Exploration of the Practice Placement Experience of Higher Education Student Paramedics within UK ambulance services	37	1
Occupational Stress in the Ambulance Service: a Cross-Cultural Investigation of Psychological wellbeing	11	-
The student experience of university paramedic education/training – from classroom learning to situational understanding	13	-
A case study of the English Ambulance Services	16	1

* From 1st September 2011, research involving NHS staff no longer requires NHS REC review unless there is a legal requirement for review as specified in 'Governance arrangements for research ethics committees: a harmonised edition'

It is important to note that in addition to the above mentioned research projects, the LAS also undertakes a number of descriptive, feasibility and evaluation projects to provide evidence of the best ways to treat patients and to achieve the best possible outcomes.

In the last three years, twelve publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The publications have been published in journals including, in 2011: *'Complexity of the decision-making process of ambulance staff for assessment and referral of older patients who have fallen: a qualitative study'* published in the Emergency Medicine Journal, and in 2012: *'Predicting non-cardiac aetiology: a strategy to allocate rescue breathing during bystander CPR'* published in Resuscitation, and '*Support and Assessment for Fall Emergency Referrals (SAFER2) research protocol: cluster randomised trial of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care'* published in the British Medical Journal. Our engagement with clinical research also demonstrates the London Ambulance Service NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

Other activities which demonstrate our commitment to research as a driver for improving the quality of care and the patient experience include our Journal Clubs and Advice Surgeries. During 2012/13, we held three Journal Clubs for ambulance clinicians through which they appraised published papers that discussed renal colic, pre-eclampsia, paediatric pain management, paediatric respiratory assessment, pre-hospital triage of trauma, specialist response to out-of-hospital cardiac arrest, and acute respiratory failure. Through our monthly Advice Surgeries we provide guidance to staff interested in undertaking research and help them to develop new research protocols. In addition, journal contents pages are circulated to all staff on a monthly basis to enable them to keep up to date with published literature and emerging research evidence, and findings from our research studies are disseminated to them via the quarterly Clinical Update Bulletin.

We have an extensive collaboration portfolio for the forthcoming 2013/14 period, which includes the following studies:

- High Risk ACS (*formerly known as 'DANCE'*): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.
- Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT): RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.
- Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER 2): Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.
- Identifying emergency personnel at risk of post traumatic stress disorder (PTSD): Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics.
- Assessment of call handling speed and equity of calls from non-English speaking callers to a large metropolitan Ambulance Service: An investigation into whether call handling speed and allocated response differs between English and non-English speaking callers.
- rAAA: Modelling retrospective data for patients with a ruptured aortic abdominal or thoracic aortic aneurysm (rAAA) and control cases (other emergencies) to develop a pre-hospital triage tool to aid identification of rAAA.
- Stroke mimics: An investigation of the incidence and diagnoses of stroke mimics, and differences in responses of strokes and mimics to the ROSIER assessment tool.
- IMPROVE: Investigation of whether endovascular repair compared with open surgical repair reduces the mortality from ruptured abdominal aortic aneurysm.
- Exercise-related sudden cardiac arrest in London: A retrospective analysis of cases where cardiac arrest occurred during or after exercise to investigate incidence of, and factors related to survival from, exercise-related cardiac arrest.
- Direct conveyance of cardiac arrest STEMI patients to HACs: A retrospective analysis of survival in cardiac arrest patients with ST-elevation conveyed to a Heart Attack Centre (HAC).
- Direct conveyance of non-STEMI cardiac arrest patients to HACs: A retrospective analysis of survival in cardiac arrest patients without ST-elevation conveyed to a Heart Attack Centre (HAC).
- Risk of sudden cardiac death in epilepsy: A retrospective analysis of data from patients in cardiac arrest with a history of epilepsy to identify whether patients with epilepsy are at higher risk of cardiac arrest.
- Ethnicity and survival from cardiac arrest: A retrospective analysis investigating the relationship between ethnicity and survival from cardiac arrest.
- Out-of-Hospital Cardiac Arrest Outcomes project: Development of a national cardiac arrest registry and use of statistical modelling to understand variability in outcomes and contributory factors to survival.
- An Explorative Assessment of London's 999 Frequent Callers and the Effectiveness of Interventional Strategies Employed by the London Ambulance Service's Patient Centred Action team: A retrospective analysis aiming to i) profile this group of patients, ii) examine the impact of the LAS Patient Centred Action Team's interventional strategies on frequent caller behaviour.

In addition to the above, we have developed a number of research protocols for which we are awaiting external funding decisions.

Ambulance Quality Indicators Care Bundle

The percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle

The London Ambulance Service NHS Trust submitted the following information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2012/13 and 2011/12:

	2012-13 *		2011-12	
	LAS average	**National average** (Range)	**LAS average**	**National average** (Range)
STEMI patients	67.5	74.1 (67.5 - 93)	61.7	77.6 (59.6 - 93.2)
Stroke patients	94.2	94.2 (90.4 - 100)	91.3	95.6 (85.9 - 98.9)

- *At the point of preparation of this Quality Account, NHS England reported data for April to November 2012.*

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: this data is captured by the LAS from clinical records completed by ambulance staff attending patients as part of ongoing clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The London Ambulance Service NHS Trust has taken the following actions to improve the percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle, and so the quality of its services, by:

- Improving clinical education provided to staff through materials such as clinical podcasts and other multimedia packages, training updates with associated aide memoires, bulletins and newsletters.
- Ensuring that staff have the necessary equipment to perform patient assessments.
- Reviewed pain management practices to enhance the analgesia component of the STEMI care bundle and introduced clear guidelines for step-wise pain management using a pain assessment tool to assess the severity of the patient's pain and treat with pain relief as appropriate.

Statement Area 5: CQUINS

A proportion of the London Ambulance Service NHS Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the commissioning for Quality and Innovation payment framework.

The details of the agreed goals for 2012/13 are as follows:

1. ED Conveyance & Appropriate care pathways (ACPs):
i. Increased see and treat/refer rates (no convey) (maximum £373,427, achieved £15,559)
ii. Increased use of ACPs (conveyance to destinations alternative to emergency departments (maximum £311,189, achieved £49,790)
iii. Reduction in Emergency Department conveyance rate (maximum £373,427, achieved £156,839)
2. Hear and Treat resolution (no convey) via clinical telephone advice:
i. (maximum £497,402, achieved £295,264)
3. Improved management of long term conditions – diabetes:
i. Patients having hypoglycaemic episodes (maximum £248,951, achieved £99,580)
ii. Patients with undiagnosed diabetes with raised blood glucose levels (maximum £248,951, achieved ££99,5800
4. Improved management of patients with alcohol related needs/health promotion
i. Alcohol recovery centres (maximum £560,140, achieved £535,245)
ii. Alcohol health promotion (maximum £ 373,427, achieved £186,713)
5. Data sharing and improvement in data capture:
i. NHS number collection – 5 sites piloting different methods (maximum £497,902, achieved £497,902)
ii. Patient level data shared with LAS commissioning team (£497,902, achieved £497,902)

iii. Frequent caller data – sharing cluster based data (£248,951, achieved £128, 210)
6. 4 patient experience based activities:
i. A focus on calls receiving a long response and those involving bariatric patients (maximum £186,713, achieved £111,010)
ii. Use of the emergency & urgent care toolkit as an audit system in the Clinical Hub (maximum £186,713, achieved £186,713)
iii. Feedback from non-conveyed patients (maximum £186,713, achieved £186,713)
iv. Compliance against core skills refresher training (maximum £186,713, achieved £18,671)
7. Workforce changes:
i. Implementation of new rest break policy (maximum £497,902, achieved £0)
ii. Complete a roster review (maximum £497,902, achieved £497,902)
iii. Implement a new annual leave process/policy (maximum £248,951, achieved £248,951)

The details of the agreed goals for 2013/14 are as follows:

Workforce Changes

1. Workforce skill mix: Delivery of training to support 2-tier working
Detail: This is measured by the percentage of A&E support staff that have commenced the conversion course to enable front-line working (excluding those who may not be eligible through sickness, maternity or other issues, as well as recognising there may be some staff who may not be capable of achieving the required standards).
£1,740,331

2. Roster development across all areas/teams: Development of new roster patterns for all appropriate complexes and teams
Detail: Achievement will be measured against the development of a full set of new rosters that are in line with ORH modelling results. Note that this is not about implementation of these rosters. £2,370,886

Efficiencies

1. Enhanced clinical triage process implemented: Recruitment of additional staff within the Clinical Hub to the new role which is targeted to deliver hear and treat
Detail: The achievement measure is completion of the recruitment process to fill the Clinical Hub positions.
£781,888

2. New response model implemented: Full implementation of CommandPoint changes to dispatch protocols to support the changes to a 2-tier working
Detail: This has a simple measure of achievement – whether it is implemented or not within the agreed timescale. £807,110

Staff Engagement

1. Engagement exercise and communications strategy delivered:
Completion of a series of staff engagement events including delivery of a comprehensive information pack to staff
Detail: This is recognised as an ongoing process which will involve regular checkpoint reports to the steering group.
£605,333

Statement Area 6: Care Quality Commission

The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is “registered”. The London Ambulance Service NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The London Ambulance Service NHS Trust during 2012/13.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2012/13.

Statement Area 7 Data Quality

The London Ambulance Service NHS Trust will be taking the following actions to improve data quality:

At the time of writing the Quality Account the Trust was in discussion with the internal auditors as to what aspects would feature within the audit programme. Data Quality will feature in at least one audit project.

Statement Area 8 NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics

which are included in the latest published data.

The London Ambulance Service NHS Trust was not required to submit records during 2012/13 using patients' valid General Medical Practice Code.

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score for 2012/13 was 82% and was graded at level 2.

Statement area 10 Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

Ambulance Quality Indicators

A review of the 2012/13 Quality Indicators

2012/13 was the second year of the national ambulance quality indicators. These are a set of measures that allow individual Ambulance Trusts to look where they lie in comparison with other NHS ambulance providers.

It is not always possible to draw direct comparisons as services differ slightly across the country but it allows Ambulance Trusts to use the information analytically.

The following graphs illustrate the London Ambulance Service NHS Trust year end position in all 12 quality measures. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking therefore the data for those includes data from April to December 2012.

Measure 1. Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is an acronym meaning 'ST (a particular segment) Elevation Myocardial Infarction', which is a type of heart attack. Early access to cardiac intervention is considered an important element in reducing the mortality and morbidity associated with a STEMI.

There are three elements to this quality measure the first two of which measure speed or time. The final element measures the care undertaken by the clinical staff employed in the ambulance service and asks Trusts to record when aspirin is given, when Glyceryl Trinitrate (GTN) is given, when 2 pain scores are recorded and when a patient has received analgesia of either Morphine or Entenox.

Element 1; Percentage of patients suffering a ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call (Year end position)

The London Ambulance Service NHS Trust does not participate in this measure as the service does not administer thrombolysis. This is because there are no areas within the Trust's catchment where an appropriate hospital that can administer the intervention can be accessed within the hour. This is different in other areas in the country where Accident & Emergency departments are some distance away so ambulance clinical staff are trained to deliver the intervention.

Element 2; Graph 1: Percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	93.8	732	780	93.8
East of England Ambulance Service	91.9	682	742	91.9
Great Western Ambulance Service	89.9	328	365	89.9
Isle of Wight	57.1	8	14	57.1
London Ambulance Service	91.7	959	1,046	91.7
North East Ambulance Service	90.2	788	874	90.2
North West Ambulance Service	87.1	990	1,137	87.1
South Central Ambulance Service	89.9	596	663	89.9
South East Coast Ambulance Service	88.0	508	577	88.0
South Western Ambulance Service	82.4	490	595	82.4
West Midlands Ambulance Service	84.0	673	801	84.0
Yorkshire Ambulance Service	82.5	898	1,089	82.5
Overall for period	**Higher is better**	7,652	**8,683**	**88.1**

Our compliance was 91.9% last year and this year we are at 91.7% suggesting a stable performance with this quality indicator.

Element 3; Graph 2: Percentage of patients suffering a STEMI who receive an appropriate care bundle (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	75.3	782	1,038	75.3
East of England Ambulance Service	83.2	1,023	1,229	83.2
Great Western Ambulance Service	94.1	332	353	94.1
Isle of Wight	88.2	30	34	88.2
London Ambulance Service	67.3	1,349	2,004	67.3
North East Ambulance Service	84.7	553	653	84.7
North West Ambulance Service	83.1	1,529	1,840	83.1
South Central Ambulance Service	68.5	686	1,001	68.5
South East Coast Ambulance Service	77.4	656	847	77.4
South Western Ambulance Service	82.9	1,126	1,358	82.9
West Midlands Ambulance Service	72.4	639	883	72.4
Yorkshire Ambulance Service	78.8	928	1,178	78.8
Overall for period	**Higher is better**	9,633	**12,418**	**77.6**

Our compliance is 67.3% and last year our compliance was 59.5% suggesting we have made improvements in this quality indicator.

Measure 2. Outcome from cardiac arrest - return of spontaneous circulation.

The aim of this indicator is to reduce the mortality associated with a cardiac arrest. The indicator measures the overall effectiveness of the urgent and emergency care services by considering how many patients have a pulse or heartbeat on arrival to hospital following a cardiac arrest. However, it is known that those patients who have their cardiac arrest witnessed are more likely to survive the episode than those who have a cardiac arrest while unobserved. This significantly shortens the length of time that it takes the emergency services to respond.

Therefore, the measure is broken into two indicators. The first counts all of the cardiac arrests whilst the second counts only those that are witnessed.

Element 1; Graph 4 Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall) (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	17.5	398	2,270	17.5
East of England Ambulance Service	21.7	512	2,358	21.7
Great Western Ambulance Service	26.4	257	973	26.4
Isle of Wight	23.6	17	72	23.6
London Ambulance Service	30.9	1,008	3,264	30.9
North East Ambulance Service	24.6	310	1,261	24.6
North West Ambulance Service	26.7	772	2,886	26.7
South Central Ambulance Service	35.8	314	876	35.8
South East Coast Ambulance Service	25.1	475	1,891	25.1
South Western Ambulance Service	25.0	429	1,713	25.0
West Midlands Ambulance Service	27.6	474	1,718	27.6
Yorkshire Ambulance Service	21.4	485	2,270	21.4
Overall for period	**Higher is better**	5,451	**21,552**	**25.3**

Residents and visitors to London appear to continue to have a good outcome with 30.9% of all cardiac arrests having a pulse, or heartbeat, on arrival at hospital. Last year our compliance was 29.4% suggesting a stable performance.

Element 2; Graph 5 Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein) (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	40.2	158	393	40.2
East of England Ambulance Service	52.6	173	329	52.6
Great Western Ambulance Service	55.3	78	141	55.3
Isle of Wight	37.5	3	8	37.5
London Ambulance Service	54.9	225	410	54.9
North East Ambulance Service	49.4	88	178	49.4
North West Ambulance Service	45.3	175	386	45.3
South Central Ambulance Service	49.5	49	99	49.5
South East Coast Ambulance Service	45.9	119	259	45.9
South Western Ambulance Service	40.1	103	257	40.1
West Midlands Ambulance Service	40.6	88	217	40.6
Yorkshire Ambulance Service	46.0	159	346	46.0
Overall for period	**Higher is better**	1,418	**3,023**	**46.9**

London has the highest number of witnessed arrests and again the table shows a good outcome with 54.9% of witnessed cardiac arrests having a pulse or heartbeat on arrival at hospital. Last year our compliance was 53.7% suggesting a stable performance.

Measure 3. Outcome from cardiac arrest - survival to discharge

Following on from the second indicator, this one measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital. Again this is broken into the all cardiac arrest group and the witnessed cardiac arrest group.

Element 1; Graph 6 Survival to discharge – Overall survival rate (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	7.8	172	2,192	7.8
East of England Ambulance Service	6.0	137	2,295	6.0
Great Western Ambulance Service	10.8	105	973	10.8
Isle of Wight	4.2	3	72	4.2
London Ambulance Service	8.0	256	3,189	8.0
North East Ambulance Service	6.1	75	1,221	6.1
North West Ambulance Service	7.5	176	2,350	7.5
South Central Ambulance Service	15.0	119	794	15.0
South East Coast Ambulance Service	6.1	110	1,809	6.1
South Western Ambulance Service	8.8	150	1,699	8.8
West Midlands Ambulance Service	7.0	121	1,718	7.0
Yorkshire Ambulance Service	8.0	178	2,238	8.0
Overall for period	**Higher is better**	1,602	**20,550**	**7.8**

This shows that 8.0% of all patients who had a cardiac arrest in the London region survived to be discharged from hospital. Last year our compliance was 9.5% suggesting a slight drop in performance across London but the numbers are not large enough to draw any clinical conclusions.

Element 2; Graph 7: Survival to discharge – Utstein comparator group survival rate (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	11.6	42	361	11.6
East of England Ambulance Service	24.3	73	300	24.3
Great Western Ambulance Service	31.9	45	141	31.9
Isle of Wight	42.9	3	7	42.9
London Ambulance Service	27.3	104	381	27.3
North East Ambulance Service	25.1	42	167	25.1
North West Ambulance Service	19.9	57	286	19.9
South Central Ambulance Service	20.7	19	92	20.7
South East Coast Ambulance Service	16.7	39	233	16.7
South Western Ambulance Service	22.4	57	255	22.4
West Midlands Ambulance Service	13.7	28	204	13.7
Yorkshire Ambulance Service	28.1	94	335	28.1
Overall for period	**Higher is better**	603	**2,762**	**21.8**

This graph really demonstrates the benefits to outcome when a cardiac arrest is witnessed as this shows that 27.3% of all patients who had a cardiac arrest witnessed in the London region survived to be discharged from hospital and is regarded as a better indicator than the previous element (element 1 graph 6). Last year the compliance was 30.3% suggesting a slight drop in performance across London but the numbers are not large enough to draw any clinical conclusions.

Measure 4. Outcome following stroke for ambulance patients

Patients should be arriving at an appropriate place as soon as possible following the onset of a stroke. Time to confirmed diagnosis and treatment is key to reducing mortality associated with a stroke. This indicator requires ambulance services to measure the time it takes from the 999 call to the time it takes those positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for thrombolysis treatment.

There are two indicators to this measure. The first records the time and the second considers the care given by ambulance clinical staff. The care should include the completion of a stroke diagnostic test (called a FAST test), the checking of a patient's blood glucose and a complete blood pressure taken.

Element 1; Graph 8: Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	48.2	443	919	48.2
East of England Ambulance Service	47.6	1,008	2,119	47.6
Great Western Ambulance Service	61.9	447	722	61.9
Isle of Wight	68.1	62	91	68.1
London Ambulance Service	67.8	3,002	4,425	67.8
North East Ambulance Service	78.5	1,210	1,541	78.5
North West Ambulance Service	79.9	2,420	3,028	79.9
South Central Ambulance Service	49.0	702	1,432	49.0
South East Coast Ambulance Service	61.6	2,276	3,693	61.6
South Western Ambulance Service	53.9	1,110	2,061	53.9
West Midlands Ambulance Service	64.2	1,132	1,763	64.2
Yorkshire Ambulance Service	64.8	2,177	3,359	64.8
Overall for period	**Higher is better**	15,989	**25,153**	**63.6**

Our compliance this year is 68.1% and last year our compliance was 65.1% suggesting a small improvement. However the actual number of patients conveyed within 60 minutes last year was 2,590 and this year the number of patients conveyed within 60 minutes was 3,002. We can not draw any clinical conclusions from the increase.

Element 2; Graph 9: Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	96.0	7,268	7,574	96.0
East of England Ambulance Service	95.7	5,311	5,552	95.7
Great Western Ambulance Service	100.0	1,215	1,215	100.0
Isle of Wight	93.7	388	414	93.7
London Ambulance Service	94.1	7,131	7,581	94.1
North East Ambulance Service	97.2	2,998	3,083	97.2
North West Ambulance Service	99.0	8,205	8,285	99.0
South Central Ambulance Service	97.0	4,705	4,852	97.0
South East Coast Ambulance Service	90.7	4,915	5,416	90.7
South Western Ambulance Service	95.5	5,207	5,450	95.5
West Midlands Ambulance Service	94.6	5,702	6,027	94.6
Yorkshire Ambulance Service	94.6	6,071	6,418	94.6
Overall for period	**Higher is better**	59,116	**61,867**	**95.6**

Our compliance this year is 94.1% and last year our compliance was 90.0% suggesting a slight improvement.

Measure 5. Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

This indicator reflects how the whole urgent care system is working, rather than simply the ambulance service or Accident & Emergency, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

This is a single indicator that is simply made up of the number of calls where the London Ambulance Service provided an intervention where an ambulance was not required.

Graph 10: Percentage of 999 calls that have been resolved by providing telephone advice (Year end position)

	Numerator	Calls	%
East Midlands Ambulance Service	43,083	612,765	7.0
East of England Ambulance Service	46,091	690,612	6.7
Great Western Ambulance Service	13,705	189,037	7.2
Isle of Wight	1,731	21,050	8.2
London Ambulance Service	68,479	1,156,289	5.9
North East Ambulance Service	13,292	329,795	4.0
North West Ambulance Service	29,905	862,887	3.5
South Central Ambulance Service	19,414	396,342	4.9
South East Coast Ambulance Service	55,709	574,218	9.7
South Western Ambulance Service	26,576	413,211	6.4
West Midlands Ambulance Service	50,876	775,045	6.6
Yorkshire Ambulance Service	30,030	609,607	4.9
Overall for period **Higher is better**	398,891	**6,630,858**	**6.0**

Our compliance is 5.9%. Last year our compliance was 6.4% suggesting we conveyed a greater proportion of patients to accident and emergency this year.

Measure 6. Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time this indicator will measure how many callers or patients call the Ambulance Trust back within 24 hours of the initial call being made.

The measure is broken down into 2 indicators. The first is the number of patients that call back following clinical advice over the telephone and the second is the number of patients that call back after being given an intervention at home and discharged (not taken to Accident & Emergency).

Element 1. Graph 11:Percentage re-contact following discharge of care by telephone (Year end position)

	Numerator	Incidents	%
East Midlands Ambulance Service	1,481	43,083	3.4
East of England Ambulance Service	7,080	46,091	15.4
Great Western Ambulance Service	1,489	13,705	10.9
Isle of Wight	45	1,731	2.6
London Ambulance Service	2,002	68,479	2.9
North East Ambulance Service	2,101	13,292	15.8
North West Ambulance Service	9,316	29,905	31.2
South Central Ambulance Service	3,623	19,414	18.7
South East Coast Ambulance Service	7,243	55,709	13.0
South Western Ambulance Service	4,137	26,576	15.6
West Midlands Ambulance Service	7,532	50,876	14.8
Yorkshire Ambulance Service	5,906	30,030	19.7
Overall for period **Lower is better**	51,955	**398,891**	**13.0**

The compliance this year is 2.9% and last year our compliance was 5.2% suggesting an improved position and sustaining our position of the second lowest re-contact rate following telephone advice.

Element 2. Graph 12: Percentage re-contact rate following discharge of care on scene (Year end position)

		Numerator	Incidents	%
East Midlands Ambulance Service	6.3	11,449	180,424	6.3
East of England Ambulance Service	7.7	20,249	262,465	7.7
Great Western Ambulance Service	4.0	2,919	73,429	4.0
Isle of Wight	2.4	143	5,968	2.4
London Ambulance Service	5.4	13,444	249,071	5.4
North East Ambulance Service	5.0	3,597	72,106	5.0
North West Ambulance Service	6.4	10,827	168,212	6.4
South Central Ambulance Service	7.0	11,376	161,717	7.0
South East Coast Ambulance Service	4.7	9,001	189,797	4.7
South Western Ambulance Service	6.6	11,608	175,415	6.6
West Midlands Ambulance Service	5.2	13,454	256,511	5.2
Yorkshire Ambulance Service	8.5	10,872	127,619	8.5
Overall for period	**Lower is better**	118,939	**1,922,734**	**6.2**

Our compliance this year is 5.4% and last year our compliance was 4.3% suggesting a small increase.

Measure 7. Call abandonment rate

This indicator measures if patients phoning 999 and not being able to get through and are hanging up before being answered.

Graph 13: Percentage of calls abandoned before being answered (Year end position)

		Numerator	Calls	%
East Midlands Ambulance Service	0.9	6,059	685,921	0.9
East of England Ambulance Service	0.6	6,071	938,821	0.6
Great Western Ambulance Service	0.6	1,888	307,881	0.6
Isle of Wight	1.6	367	23,484	1.6
London Ambulance Service	0.1	1,805	1,588,181	0.1
North East Ambulance Service	2.2	11,044	504,420	2.2
North West Ambulance Service	2.9	31,269	1,085,945	2.9
South Central Ambulance Service	2.2	9,871	448,143	2.2
South East Coast Ambulance Service	3.3	20,367	622,060	3.3
South Western Ambulance Service	1.2	6,732	577,698	1.2
West Midlands Ambulance Service	0.9	9,032	955,998	0.9
Yorkshire Ambulance Service	2.4	18,971	806,347	2.4
Overall for period	**Lower is better**	123,476	**8,544,899**	**1.4**

Our compliance is 0.1% the same as last year. This is the lowest rate across the country.

Time to answer calls

It is equally important that if patients dial 999 that they get their call answered quickly. This indicator measures how quickly all 999 calls that are received are answered**.**

No Graph Percentage of calls abandoned before being answered (Year end position)

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 0.0 seconds 2) 95th percentile where we achieve a rate of 0.07 seconds and 3) the 99th percentile where we achieve a rate of 0.51 seconds.

Measure 8. Service experience

All ambulance services need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how they are acting on that information to continuously improve patient care.

There is no mandatory element and each individual Trust is able to decide how they meet the expectations of this measure. The London Ambulance Service NHS Trust now produce a quarterly Service Experience report that brings together all the elements of patient experience and patient feedback.

Measure 9. Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and records only those who are most in need of an emergency ambulance. It is divided into two measures. The first is the length of time taken to respond within an eight minute window and the send measure is the time taken to respond in a 19 minute window. The first 8 minute response is divided into two subdivisions known as Red 1 and Red 2. Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse,and other severe conditions. For Red 2 calls, is used for conditions which are less serious and less immediately time critical and cover conditions such as stroke and fits.

Element 1. Graph 14: Category A 8 Minute Response Time (Year end position) for Red 1.

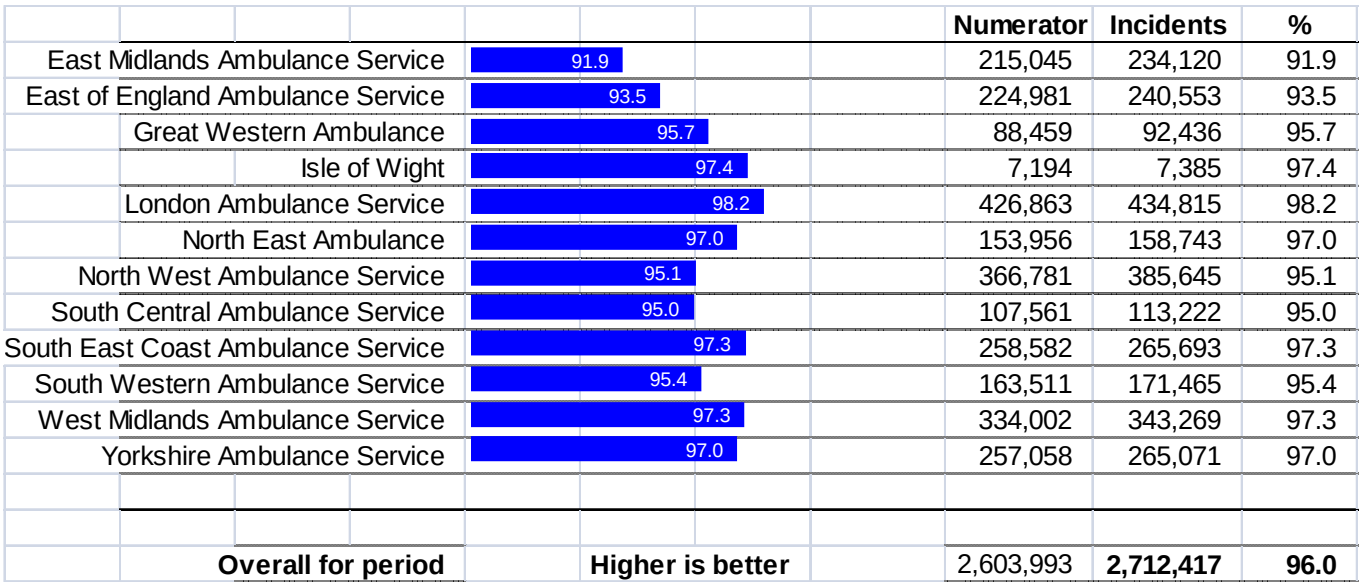
		Numerator	Incidents	%
East Midlands Ambulance Service	70.0	13,353	19,063	70.0
East of England Ambulance Service	74.2	7,335	9,892	74.2
Great Western Ambulance	75.3	3,782	5,021	75.3
Isle of Wight	78.7	118	150	78.7
London Ambulance Service	77.7	9,445	12,148	77.7
North East Ambulance	76.6	2,061	2,691	76.6
North West Ambulance Service	73.5	20,400	27,757	73.5
South Central Ambulance Service	78.2	5,038	6,439	78.2
South East Coast Ambulance Service	75.1	3,684	4,906	75.1
South Western Ambulance Service	73.0	3,119	4,272	73.0
West Midlands Ambulance Service	78.9	5,179	6,561	78.9
Yorkshire Ambulance Service	71.7	11,091	15,473	71.7
Overall for period	**Higher is better**	84,605	**114,373**	**74.0**

Element 1. Graph 15: Category A 8 Minute Response Time (Year end position) for Red 2.

		Numerator	Incidents	%
East Midlands Ambulance Service	75.5	134,726	178,419	75.5
East of England Ambulance Service	72.8	141,170	193,921	72.8
Great Western Ambulance	76.9	53,554	69,667	76.9
Isle of Wight	76.6	4,632	6,046	76.6
London Ambulance Service	76.3	270,603	354,646	76.3
North East Ambulance	76.5	100,150	130,911	76.5
North West Ambulance Service	76.6	226,567	295,664	76.6
South Central Ambulance Service	75.2	67,459	89,729	75.2
South East Coast Ambulance Service	75.1	161,481	215,110	75.1
South Western Ambulance Service	75.9	108,824	143,314	75.9
West Midlands Ambulance Service	75.5	212,393	281,182	75.5
Yorkshire Ambulance Service	75.2	155,362	206,533	75.2
Overall for period	**Higher is better**	1,636,921	**2,165,142**	**75.6**

The graphs reveal that the London Ambulance Service achieved the requirement to complete 75% of all A8 calls within eight minutes.

Element 2. Graph 16: Category A 19 Minute Response Time (Year end position)



		Numerator	Incidents	%
East Midlands Ambulance Service	91.9	215,045	234,120	91.9
East of England Ambulance Service	93.5	224,981	240,553	93.5
Great Western Ambulance	95.7	88,459	92,436	95.7
Isle of Wight	97.4	7,194	7,385	97.4
London Ambulance Service	98.2	426,863	434,815	98.2
North East Ambulance	97.0	153,956	158,743	97.0
North West Ambulance Service	95.1	366,781	385,645	95.1
South Central Ambulance Service	95.0	107,561	113,222	95.0
South East Coast Ambulance Service	97.3	258,582	265,693	97.3
South Western Ambulance Service	95.4	163,511	171,465	95.4
West Midlands Ambulance Service	97.3	334,002	343,269	97.3
Yorkshire Ambulance Service	97.0	257,058	265,071	97.0
Overall for period	**Higher is better**	2,603,993	**2,712,417**	**96.0**

The graph reveals that the London Ambulance Service achieved the requirement to complete 95% of all calls within 19 minutes.

Measure 10. Time to treatment by an ambulance-dispatched health professional

It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

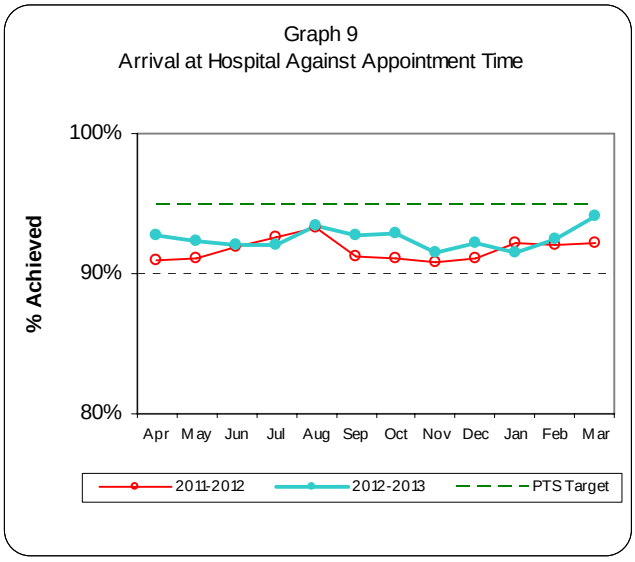
No Graph Time to treatment by an ambulance-dispatched health professional (Year end position)

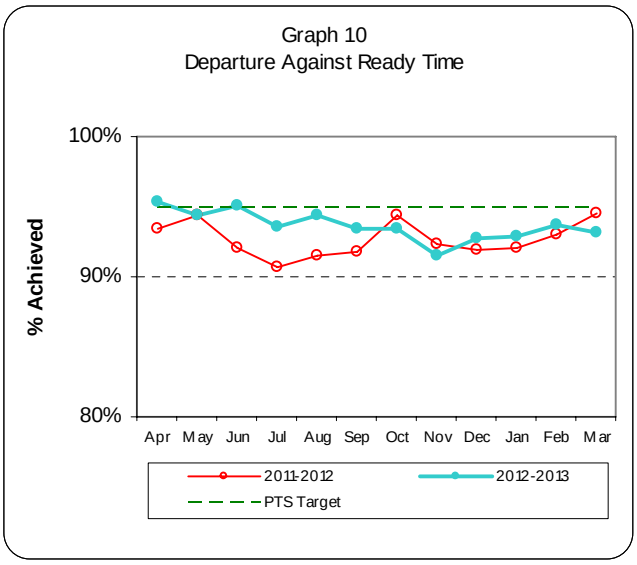
There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 5.49 minutes 2) 95th percentile where we achieve a rate of 14.10 minutes and 3) the 99th percentile where we achieve a rate of 22.23 minutes. These figures are consistent with other ambulance services.

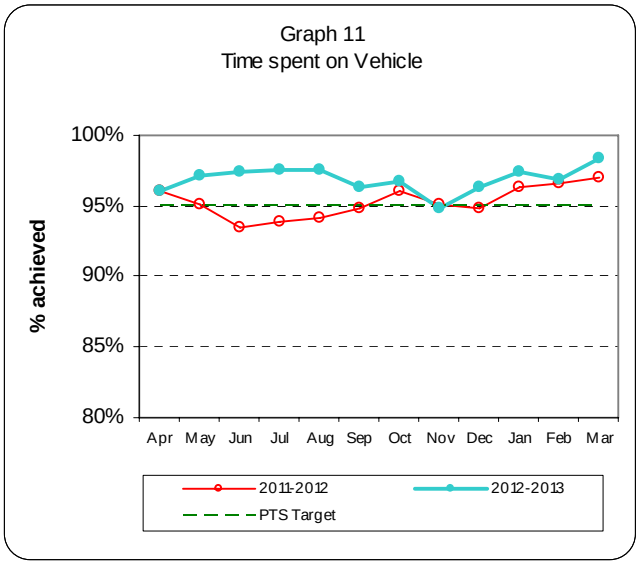
Patient Transport Services

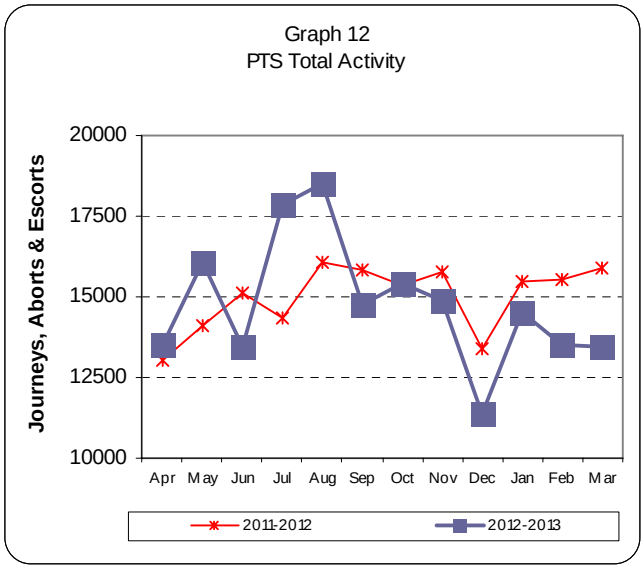
We are commissioned by a number of London NHS Trusts and PCTs to provide non-emergency patient transport for patients attending hospital or clinic appointments carried out by, or on behalf of, the contracting Trust/PCT. Each contract is specific to the requirements of the individual organisation and therefore the scope of each contract is different. For example, hours of operations, areas covered, types of patients conveyed. However we have a number of quality standards that we strive to achieve across our Patient Transport Service.

Graph 17: The percentage of patients who arrive within an agreed time frame of their appointment









2013/14 Quality Priorities

Our improvement priorities for the coming year

With a rise in over 100,000 calls in 2012/13 and with 47,000 of these being category A calls we have found it increasingly difficult to meet the expectations of our lower priority patients. Our resources are always directed towards the higher priority patients which means at times of high category A demand, such as late evening, these patients wait an unacceptable length of time.

We have agreed with our commissioners that we need to focus our improvement work on our less urgent patients in 2013/14. However, the programme of work required to make the necessary improvements is so complex that we have agreed that these improvements should span a number of years.

Fundamentally we need to improve the way that we use our resources. At peak times we simply do not have enough staff who are available and consequently patients have to wait until our clinical staff have finished with the previous patient. This means some patients can wait for a long time.

Our commissioners have invested in the service this year and this investment will allow us to increase the number of staff that we employ. However, this is not the whole story. Over time we have become increasingly inefficient and our current operating model is not allowing us to use our resources in the most effective way.

Therefore we have proposed a number of changes that will lead to a modernisation of the service.

Service Modernisation

At the time of writing the quality account our proposals are with our staff for consultation and it would be inappropriate to outline each individual project here as an agreed improvement priority as the detail may change.

However, each of the individual proposals will help us support a workforce that is more skilled and is less constrained by current practices and the operating model. If successful our vision for 2015 includes the following;

- Each patient who rings 999 will have a response within 1 hour. Either by telephone assessment or by a clinician attending to them directly.
- Our working rosters will enable us to match ambulance availability with 999 call demand.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to appropriate healthcare options.
- Patients will experience a seamless referral to appropriate providers, for example, NHS 111, crisis and falls teams.
- Every patient who requires a face to face assessment will be attended within an hour by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.
- We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

The implementation of the modernisation programme is one of our four main priorities for 2013/14.

Priorities for 2013/14

We have identified four priority areas for 2013/14.

- The implementation of the modernisation agenda.
- To improve communication and engagement
- Sustain performance to ensure a safe service to patients
- Build a sustainable financial position for 2014/15 and beyond

We will work with the Trust Board to identify what specific projects and measures need to be identified to ensure success in each area.

Improving the care of less urgent patients

Our modernisation programme is focussed on making the changes necessary to improve services for our lower category patients. However we have agreed to focus our broader quality work on this group of patients and our Quality Committee has tasked the Learning from Experience Committee to try and make four specific improvements.

Attitude and Behaviour

We employ excellent staff and we are proud of the job that we do. Occasionally we receive complaints where the patient, or carer, has found the need to cite attitude or behaviour as a reason for having a poor experience of our service.

In 2012/13 we received 288 complaints regarding attitude and behaviour.

On examination of the complaints these are almost exclusively from our lower category calls and are most likely to occur when our staff challenge the reason for calling an ambulance. We will look at this issue further during 2013/14 with the intention of lowering the number of complaints on this issue.

Improving the Experience of Patients subjected to a Delay

Our modernisation programme will allow us to eventually improve the delay. However, we want to explore if we can improve the experience of patients who have a delay. Last year we had 441 complaints regarding a delay.

Waiting for a clinician to arrive having made a 999 call is stressful. Whilst we may not have categorised certain calls as a high priority we recognise for those at the scene they require assistance quickly.

Some patients tell us that they would like to receive information about how long they may have to wait so that they can make a choice. This is extremely difficult for us to do but we will look at ways to see if we can improve the experience of patients who are subject to a delay.

Improving the Experience of Patients Referred to Alternative Care Pathways

There is a perception that a 999 call will automatically result in conveyance to accident & emergency. This is no longer the case and with our staff becoming more advanced in their clinical skills we are able to resolve a number of calls without the need to convey a patient to accident & emergency. For some patients we are able to offer an alternative such as an urgent care centre or local district services.

This is not always what is expected and can lead to dissatisfaction. We need to build upon our 2012/13 satisfaction survey of patients who have not been conveyed to hospital and ensure we implement the service experience improvements identified from that work.

Equipment

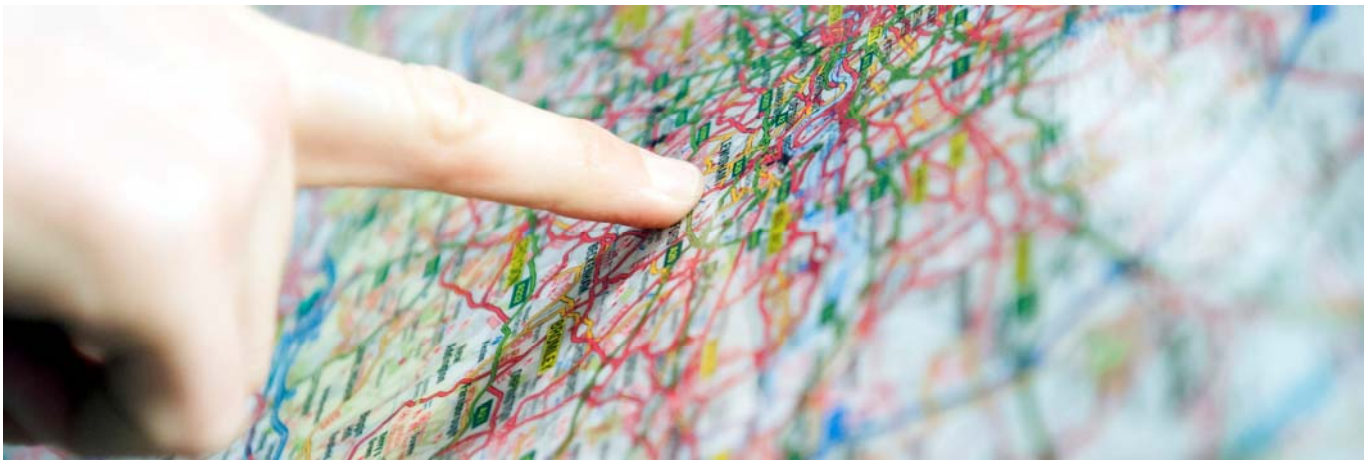
The nature of our mobile service means we can accidentally leave equipment at the roadside or in patient's home which means it may not be available for the next patient. This does not affect our bulky life saving equipment but smaller items such as blood testing kits or equipment used in patient assessment.

This issue was identified in our 2012 Care Quality Commission inspection and we agreed to look for methods that would reduce the incidence of lost equipment.

If we can make significant improvements in this area we will improve the assessment we are able to offer our patients, improve our staff's satisfaction in their ability to do a good job and improve the pressure on our finances.

Stakeholder Comments

The feedback we have received on this Quality Account



Feedback
A number of organisations were invited to comment on the Quality Account

Hillingdon Oversight and Scrutiny Committee
No response was received from the committee.

London Ambulance Commissioners
The chair of the Strategic Commissioning Board made a suggestion that the Trust should include a summary of our work on continuous learning. This was added to page 15.

Our commissioners also made the following response:

The London Ambulance Commissioning Consortium works on behalf of the 32 CCGs across London to commission an urgent and emergency ambulance service; a collaborative approach to commissioning ensures that London Ambulance Service is able to provide a consistent standard of care with a high level of resilience.

A robust ambulance service is highly valued by the public, and the reassurance that people who are in life threatening situations will get a response quickly with good clinical outcomes is important and in this respect, London Ambulance Service has some of the best clinical outcomes when compared to other ambulance trusts in England. We are keen to see a development of the wider measures of the effectiveness of the service. In 2012/13 a range of clinical outcome measures have been reported and these demonstrate overall good clinical outcomes from patient care. During 2013/14 we will work with London Ambulance Service to develop ways to record NHS numbers so that we can start to expand the measurement of overall outcomes of care pathways; we currently measure the patient outcomes from cardiac arrest so we can identify those patients that survive to be discharged from hospital; by measuring this information we will be able to improve patient outcomes by identifying those interventions and hospitals that have better outcomes.

Every year the number of people who ring 999 with an urgent care need increases but not all patients need an ambulance; during 2012/13 London Ambulance Service continued to ensure that a patient receives the most appropriate response, or is directed to a suitable alternative service. By offering patients appropriate alternatives to ambulance responses we have again this year seen a lower proportion of people being taken to hospital, and more people being treated by advice, in their own home, or via other alternative care settings. The reduction in transfers to hospital will remain a high

priority for the ambulance service to ensure that hospital services remain available to those people that really need them.

During 2012/13 the London Ambulance Service and Commissioners funded an independent review of the capacity of the service to continue to deliver high quality services for the population moving forward. During 2013/14 investment by Commissioners will enable London Ambulance Service to deliver important improvements to the delivery of care.

2012/13 has been an eventful year on the world stage with the 2012 Olympic Games and the Queen's Diamond Jubilee celebrations taking place in the capital city resulting in significant additional pressures resulting for London Ambulance Service. It was reassuring that staff not only coped with this demand, but provided exemplary service to the public in a time of extreme pressure, demonstrating a robust and resilient service that is able to draw on support from other ambulance trusts in a safe and effective way.

There are occasions when service standards are not acceptable, and during 2012/13 there were regrettably a small number of occasions where this was the case. London Ambulance Service and Commissioners work closely to ensure that lessons are learnt and improvements made; Commissioners welcome the new Duty of Candour and are assured that London Ambulance Service will be open with people on the rare occasions when something goes wrong.

Commissioners have a pivotal role in assuring the quality of the service provided by London Ambulance Service. Each month a Quality Review Group of Clinicians continue to assess the quality of care delivered and this process will continue to be strengthened, with the introduction of a series of announced and unannounced quality inspections the results of which will be reported to the Clinical Quality Review Group.

This Quality Report and Quality Accounts presents an accurate reflection of the work being undertaken by London Service to improve the quality of the service delivered, and has been fairly interpreted and presented in a way that meets the need of the target audience.

Commissioners are keen to continue and develop the excellent partnership working to ensure that people in London continue to have a high quality ambulance service that responds appropriately to patient need and achieves good clinical outcomes.

Mark Docherty
Director – London Ambulance Service Commissioning
21st June 2013

Patient Forum

Thanks so much for inviting the Patients' Forum to comment on the LAS Quality Account.

CARE OF VULNERABLE PEOPLE – URGENT CARE

The Forum is very pleased that the LAS has achieved its Cat A targets and shares your concern about the poor performance of the LAS for patients receiving care requiring a Cat C response. We are particularly concerned that these patients are often vulnerable and in need of urgent care and are sometimes having to wait long periods to receive appropriate care. These patients are high priority but not suffering from a life threatening condition.

SHIFT PATTERNS

We welcome the decision of the LAS to work with front line staff to change shift patterns. At the moment patients requiring paramedic care at shift handover times sometimes have to wait for unacceptable periods of time. These waits can impact severely on the treatment and care and prognosis of patients

A PARAMEDIC ON EVERY VEHICLE

The proposal to ensure that there is a paramedic on every vehicle is one we strongly support. However, it is essential that the current system of paramedics learning from each other's clinical experience should not be broken. Team work between health care professionals is essential and the paramedic-A&E support worker model, whilst having many strengths, must not undermine the daily communication between paramedics and the opportunities for learning from each other. The Clinical Support Desk may fulfil some of paramedics needs, but cannot replace colleague to colleague communication on clinical matters, in terms of speed of access or clinical guidance regarding a patient in front of a paramedic. This is especially important for newly trained paramedics. The clinical consequences/outcomes of this plan need to be carefully assessed.

ALTERNATIVE CARE PATHWAYS

With regard to the use of Alternative Care Pathways, which channel patients into more appropriate care and attempt to avoid the unnecessary use of A&E, we are concerned that access to these pathways is sometimes inadequate and unhelpful. Governance of ACPs is weak and in the case of the Falls and Mental Health ACPs there are serious problems re access particularly at nights and weekends.

MORE STAFF AND BETTER VEHICLES

We are very pleased that the LAS will have greatly increased resources to employ more staff and to reduce to use of voluntary and private ambulances. The cost of these alternative fill-in services is very high and is a misuse of NHS resources. It is essential that in addition to more staff that the maintenance of vehicles improves. The quality of workshop support for the maintenance and both routine and deep cleaning of vehicles is inadequate and this impacts on the safety of vehicles, the risk of infection and makes the service less efficient.

SHORTAGES OF EQUIPMENT

The Quality Report drew attention to the shortage of some types of equipment on ambulances. We were delighted to receive Sandra Adams report on June 16th about the steps taken to address these shortages. We are still getting reports of shortages of thermometers, oxygen probes, BP cuffs, ECG dots and tech packs. It is also obvious (visually) that carrying bags are often frayed and worn which creates a poor impression of the services for patients and carers.

IMPACT OF LONG SHIFTS

The Forum has expressed concern on a number of occasions about the impact of long shifts on patient care and on the health and wellbeing of front line staff. We would like to reiterate that 12 hours shift without adequate meal breaks and rest are in our view harmful to staff, harmful to patient care and generate complaints. As vehicles are now mostly on active deployment and eating in vehicles in not permitted, further work needs to take place to ensure that the shift work length and pattern is consistent with best practice for patients and staff.

HANDOVER

The Forum is pleased to note the collaborative work between the LAS and acute Trusts to reduced handover time, whilst noting there continues to be severe pressure on Croydon University Hospital. We welcome the aim to further reduced handover times. We also wish to draw the Trusts attention to the need for staff to have time to complete their clinical investigations, prepare vulnerable patients for a safe journey into the A&E department with appropriate manual handling, ensure effective clinical handover to A&E staff and ensure that vehicles are cleaned down adequately to prevent cross infection.

REPORTING TO THE NRLS – NATIONAL REPORTING AND LEARNING SYSTEM

The NRLS is a central database of patient safety incident reports set up in 2003. Information submitted is analysed to identify hazards, risks and opportunities to improve the safety of patient care. We would like the LAS to publish details of the number of incidents reported to the NRLS each month and the categories of incidents reported. As incidents are submitted confidentially, we recognise that only limited information can be put in the public arena.

DEMENTIA CARE

People with dementia are more likely to be admitted to hospital and once admitted their length of stay is longer and the experience often poor resulting in worse outcomes; worsening cognitive status and

higher mortality. Some of these admissions are for preventable ambulatory care sensitive conditions (ACSC) which could be managed in the community. But the admission rate for ACSC for people with dementia is higher than for people who do not have dementia. Problems for front line staff include difficulty in taking history and assessing pain, and viable alternatives to transport to A&E (particularly out-of-hours) for people with cognitive impairment. Dementia is not usually the main reason for a call, e.g. many are for falls, acute infection (UTIs), stroke and difficulty in breathing.
We would like to LAS to design care approaches to improve the care delivered to patients with dementia. This could include training of front line clinical staff and setting up dementia referral pathways.

USE OF CAGES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS
The LAS subcontracts for the use of caged ambulances for the transport of some patients with mental health problems. The Forum believes that the use of caged vehicles, except with the most dangerous patients, should be stopped. We believe it is an abuse of the rights of patients to be held in a cage during transport to hospital, instead of being treated with respect, dignity and care.

Malcolm Alexander
on behalf of the Patients' Forum LAS
June 21st 2013

Healthwatch Southwark

Healthwatch Southwark would like to provide the following commentary to the Quality Account. Firstly the document is well written and provides a very useful account of the quality issues within London and the service provided by the London Ambulance Service (LAS).

We would like to congratulate the LAS on the success of planning and providing an excellent service to the residents, workers and visitors within London at that time of the Diamond Jubilee, the Olympics Games and throughout the year. Also we note the achievements of 11 out of the 14 quality 2012/13 improvement priorities and the two which were partially achieved. Whilst we acknowledge that 2012-13 was a pressurised year for the LAS Mental Healthcare needs is a very important area that can often get side- tracked when there are so many other priorities. We therefore welcome the carry- over of the Mental Health related staff training (Action area 1) to 2013-14.

Regarding the service provided to residents of Southwark we will be particularly interested in the effects of the changes which will occur due to the Trust Special Administration process and Secretary of State's decisions relating to the South London Hospital Trust and health services across South East London. Of particular interest to us is the question of the effects of a smaller Accident & Emergency Department at Lewisham Hospital on the London Ambulance Service in terms of bringing patients to the other proposed A&E departments including King's College Hospital and St Thomas' Hospital departments. We would welcome contact from the LAS Community Involvement Officers and other personnel on this matter.

Healthwatch Southwark has an important role of being an advocate for the patient and public voice, alongside all Healthwatch organisations in London and we are pleased to see that the LAS takes the Patients Voice seriously and are looking at new ways of engaging at local levels as is written under the heading of Prioritising Quality.

Under the Ambulance Quality Indicators, whilst we note the increase of the LAS' compliance, it would be useful to have an explanation for the difference in the percentage of patients suffering a STEMI who receive an appropriate care bundle i.e. in London (67.3%) as compared to the highest percentage of the Great Western Ambulance Service (94.1%). We are pleased to read that LAS is planning to raise awareness of different care bundles throughout 2013/14.

Regarding the 2013/14 Quality Priorities we support the areas chosen and appreciate the honesty of the LAS in stating that there are inefficiencies in the current operating model.

As we usually tell all NHS Trusts when providing our comments to them, we would appreciate the inclusion of a Glossary for members of the public who are not familiar with terms used within the NHS.

For instance “Dashboard” and “CQUINS” could be terms included. We would also suggest an easy-read version of the document.

Finally, we look forward to hearing about the growth in relationships between the local Healthwatch organisations, including Southwark, and Healthwatch England with LAS as these bodies work towards monitoring the quality and safety of services.

Many thanks,
Alvin Kinch
Healthwatch Southwark
21st June 2013